Employee Benefit Trust of Eastern PA
Colonial Intermediate Unit 20 Employee Benefit Plan

Plan Document

July 2021

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INTRODUCTION

We provide health and welfare benefits for the eligible employees and dependents of the Colonial Intermediate Unit 20 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 Colonial Intermediate Unit 20 Employee Benefit Plan includes the following plans:

- Medical
- Prescription Drug
- Dental
- Vision

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 Colonial Intermediate Unit 20 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, 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

Dental
United Concordia Companies, Inc.
4401 Deer Path Road
Harrisburg, PA 17110
www.unitedconcordia.com
(800) 332-0366

Vision
BlueCross Vision
c/o National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015
www.capbluecross.com
(800) 905-4102

GENERAL INFORMATION

Plan Name	Colonial Intermediate Unit 20 Employee Benefit Plan
Plan Type	Self-funded health & welfare plans including: Medical and Prescription Drug plans, Dental Plan and Vision Plans
Employer Identification Number	23-1740249
Plan Number	501
Plan Dates	July 1st through June 30th
Plan Sponsor	Colonial Intermediate Unit 20 6 Danforth Drive Easton, PA 18045
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 Dental United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110 Vision BlueCross Vision c/o National Vision Administrators P.O. Box 2187 Clifton, NJ 07015

APPENDIX A

Eligibility Requirements
for Colonial Intermediate Unit 20 Employee Benefit Plan

Medical and Prescription Drug Plan

Eligible Classes of Employees:

- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Educational Support Professional Association bargaining contract
- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Transport Workers Union of America bargaining contract, except Drivers and Monitors. Drivers and Monitors should refer to the bargaining unit contract to determine eligibility
- Full-time Employees - and part-time Employees working 60% or more of the workweek as temporary professional employees, professional employees, physical therapists, occupational therapists, mental health treatment specialists or mental health workers - who are subject to the Colonial IU 20 Education Association bargaining contract
- Other Full-time Employees

Full-time is defined by the Bargaining Unit agreement

If you are an eligible Employee subject to the Educational Support Professional Association bargaining contract or the Transport Workers Union of America bargaining contract, you are eligible to enroll in medical and prescription drug benefits at the end of your probationary period.

If you are in an eligible class of employees, other than as noted above, you are eligible to enroll in medical and prescription drug benefits on the date of hire.

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.

Dental Plan

Eligible Classes of Employees:

- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Educational Support Professional Association bargaining contract
- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Transport Workers Union of America bargaining contract, except Drivers and Monitors. Drivers and Monitors should refer to the bargaining unit contract to determine eligibility
- Full-time Employees - and part-time Employees working 60% or more of the workweek as temporary professional employees, professional employees, physical therapists, occupational therapists, mental health treatment specialists or mental health workers - who are subject to the Colonial IU 20 Education Association bargaining contract
- Other Full-time Employees

Full-time is defined by the Bargaining Unit agreement

If you are an eligible Employee subject to the Educational Support Professional Association bargaining contract or the Transport Workers Union of America bargaining contract, you are eligible to enroll in medical and prescription drug benefits at the end of your probationary period.

If you are in an eligible class of employees, other than as noted above, you are eligible to enroll in medical and prescription drug benefits on the date of hire.

Eligible dependents may remain on the plan until the age of 19, or until the age of 23 if enrolled full-time as a student and unmarried.

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.

Vision Plan

Eligible Classes of Employees:

- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Educational Support Professional Association bargaining contract
- Full-time Employees and part-time Employees working 30 hours or more a week who are subject to the Transport Workers Union of America bargaining contract, except Drivers and Monitors. Drivers and Monitors should refer to the bargaining unit contract to determine eligibility
- Full-time Employees - and part-time Employees working 60% or more of the workweek as temporary professional employees, professional employees, physical therapists, occupational therapists, mental health treatment specialists or mental health workers - who are subject to the Colonial IU 20 Education Association bargaining contract
- Other Full-time Employees

Full-time is defined by the Bargaining Unit agreement

If you are an eligible Employee subject to the Educational Support Professional Association bargaining contract or the Transport Workers Union of America bargaining contract, you are eligible to enroll in medical and prescription drug benefits at the end of your probationary period.

If you are in an eligible class of employees, other than as noted above, you are eligible to enroll in medical and prescription drug benefits on the date of hire.

Eligible dependents may remain on the plan until the age of 19, or until the age of 23 if enrolled full-time as a student and unmarried.

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 - SUPPORT

Colonial Intermediate Unit 20

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

00521915

PPO

GROUP PREFERRED PROVIDER BENEFITS BOOKLET

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 Member Services 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).

ગુજરાતીમા 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

WELCOME

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

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

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

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

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

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

Let's Get Started

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

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

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

IMPORTANT NOTICES

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

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

HOW TO CONTACT US

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

Online

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

Member Services

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

Call	**800.962.2242 or TTY users, 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital BlueCross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a CapitalBlue Connect Health and Wellness Center	Go to **CapitalBlueStore.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **The Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025

DEFINITIONS

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

Allowable Amount: The maximum charge or payment level that we reimburse for *benefits* provided to you under your *coverage*.

- For *in-network providers*, the allowable amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
- For *out-of-network providers*, the allowable amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Benefits Booklet*.

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

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

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 meets the following criteria:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health (NIH)
    2. Centers for Disease Control and Prevention (CDC)
    3. Agency for Healthcare Research and Quality (AHRQ)
    4. Centers for Medicare and Medicaid Services (CMS)
    5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
    6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants.
    7. The VA, the DOD, or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
        a) The Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the NIH, and

b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug that is exempt from having such an investigational new drug application.

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

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

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

Birth Defect: Also known as congenital anomalies, congenital disorders or congenital 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 licensed *facility provider* primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

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

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

Coinsurance: The percentage of the *allowable amount* that you are responsible to pay under the group contract. *Coinsurance* percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

Copayment (Copay): The fixed dollar amount that you must pay for certain *benefits*. You may be required to pay copayments directly to the *provider* at the time of service or purchase. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

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

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

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

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

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

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

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

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

- an urban search and rescue EMS service.

A vehicle or service that provides emergency medical services outside of a healthcare facility.

Emergency Services: Any healthcare services provided to a *member* after the 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 any of the following:

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

Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

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

Facility Provider: Includes the following:

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

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

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

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

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

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

Group 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 *Benefits Booklet*, between the *contract holder* and us for the administration of *benefits*.

Group Effective Date: The date 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 us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for coverage.

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.

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

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

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

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

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

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

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.

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

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

Inpatient: When you are admitted as a patient and 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 a room and board charge is made. This term may also describe the services rendered to you while admitted.

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

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

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

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

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

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

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 hospitalization (average 25 days) and who would require high-intensity services. LTACHs are a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, the Pennsylvania Department of Health licenses LTACHs as an acute care facility.

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

Medical Necessity (Medically Necessary): Means the following

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

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

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

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

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

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

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

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

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

Out-of-Pocket Maximum: A specified dollar amount of *deductible*, *copaymen*t, and *coinsurance* expense incurred by you or your family for covered services in a *benefit period*. After you have paid this amount, you are no longer required to pay any portion of the *allowable amount* for *benefits* during the remainder of that *benefit period*. The amount of, and types of cost-sharing applied to, the out-of-pocket maximum is described in the **Summary of Cost-Sharing and Benefits** section.

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

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

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 us or our designee that results from a process used to determine your eligibility at the time of the request, *benefit* coverage and the *medical necessity* of the proposed medical services before delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this *Benefits Booklet*.

Professional Provider: Includes any of the following:

- 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 *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

Provider Incentive: An additional amount of compensation paid to a healthcare *provider* by a 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 licensed facility *provider* primarily engaged in providing diagnostic and therapeutic services for mental *healthcare*. Such services are provided by or under the supervision of an organized staff of *physicians*.

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 qualify surgery, in the absence of bodily *functional impairment*, as being *reconstructive surgery*.

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

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

Residential Treatment Facility (RTF): A licensed nonhospital *facility provider* that provides 24-hour level of care and 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 registered nurse 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 we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

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

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

- The services and supplies required for the diagnosis or treatment of complications.

Service Area: The 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.

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

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

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

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

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

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

Substance Use Disorder Treatment Facility: A *provider* licensed and approved by the state in which it provides healthcare services, or as otherwise approved by us 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 healthcare services are received.

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

Telehealth: *Medically necessary* services provided to you by a *provider* in which the method of care delivery involves interaction between you and the *provider* using 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.

HOW TO ACCESS BENEFITS

Member ID Card

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

You should show your *member ID card* and any other ID cards for other coverage each time you seek medical services. *Providers* use this information from your *member ID card* to submit claims for processing and payment.

IMPORTANT INFORMATION ABOUT YOUR MEMBER ID CARD:

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

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

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

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

Obtaining Benefits for Healthcare Services

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

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

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

Services Provided by In-Network Providers

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

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

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

Services Provided by Out-of-Network Providers

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

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

Because *out-of-network providers* are not obligated to accept our payment as payment in full, you may be responsible for the difference between the *provider's* charge for that service and the amount we 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 we pay for the service and what the *provider* charged. In addition, unless otherwise required by law, all payments are made directly to the *subscriber*; and then you are responsible for reimbursing the *provider*. Additional information on balance billing charges can be found in the **Cost-Sharing Descriptions** section.

Emergency Services

An *emergency service* is any healthcare service provided to you 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 any of the following:

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

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

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

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

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

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

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

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

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

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

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

Special Cases: Value-Based Programs

BlueCard Program

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

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

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

Blue Cross Blue Shield Global® Core

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

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

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the cost-sharing amounts (deductibles, coinsurance, etc.). In such cases, the hospital will submit the claims to the service center to begin claims processing.

However, if you pay in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. **You must contact us to obtain precertification for nonemergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

SUMMARY OF COST SHARING AND BENEFITS

The following table provides a summary of the applicable *cost-sharing amounts* and *benefits* provided under this *coverage*.

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

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

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DEDUCTIBLE (PER BENEFIT PERIOD)			
Deductible (Per Benefit Period)	$625 per *member* $1,250 per family	$1,250 per *member* $2,500 per family	Copayments and coinsurance do not apply to deductible.
OUT-OF-POCKET MAXIMUM			
Out-of-Pocket Maximum When you reach your out-of-pocket maximum, we pay all subsequent claims during the remainder of the benefit period at 100% of the allowable amount, except that coinsurance continues to apply for out-of-network facility providers.	$4,275 per *member* $8,550 per family The in-network out-of-pocket maximum includes all deductible, copayments, and coinsurance for benefits received from in-network providers.	$2,000 per member $4,000 per family The out-of-network out-of-pocket maximum includes only coinsurance for out-of-network professional providers.	The following expenses do not apply to either the in-network or out-of-network out-of-pocket maximum: • Expenses incurred for payment of a benefit after any applicable benefit period maximum has been exhausted The following expenses do not apply to the out-of-network out-of-pocket maximum: • Deductible • Copayments • Facility provider Coinsurance • Charges exceeding the allowable amount

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
ACUTE CARE HOSPITAL ROOM AND 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 SERVICES, SUPPLIES AND EDUCATION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
DIAGNOSTIC SERVICES			
Laboratory Tests	Covered in full after *deductible* when performed at an independent laboratory or drawn at a physician's office and sent to an independent laboratory. Covered in full after *deductible*, when performed at a facility/hospital owned laboratory	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospital* Laboratory *Facility* 50% *coinsurance* after *deductible* at an *Freestanding Diagnostic Facility*	
All other Medical Tests	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Radiology Services (Outpatient Facility only)	Covered in fullafter *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* Not Covered for *Freestanding Dialysis Facility Provider*	
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Durable Medical Equipment Supplier *Facility*	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services	$100 *copayment* per visit, *copayment* waived if admitted **Note: Your cost share is the same regardless of whether an in-network provider or an out-of-network provider delivers the emergency services.** (Only one ER copayment will apply for the administration of the rabies vaccine series at the initial visit/injection.)		**Refer to Emergency and Urgent Care Services benefit description for more details** Limitation within 72 hours and all follow up

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Urgent Care Services	$45 *copayment* per visit	20% *coinsurance* after *deductible*	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
ENTERAL NUTRITION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Enteral nutrition products for certain therapeutic treatments are not subject to deductible. See Benefit Descriptions section for details.
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 HEALTHCARE SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Home Health Care Agency Facility*	90 visits per *benefit period*
HOSPICE CARE			
Benefits (includes *Residential Hospice Care*)	Inpatient hospice Covered in full after *deductible* Outpatient hospice Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospice Facility*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
IMMUNIZATIONS AND INJECTIONS (NONPREVENTIVE)			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
INFERTILITY SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
INFUSION 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* for facility services Covered in full after *deductible* for professional services	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Birthing Facility*	
MEDICAL TRANSPORT			
Emergency Ambulance	Covered in full *deductible* waived **Note: Cost share is the same regardless of whether the emergency services are provided by an in-network *provider* or an *out-of-network provider*.**		
Nonemergency Ambulance	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
MENTAL HEALTHCARE SERVICES			
Inpatient Services	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital *Facility*	
Partial Hospitalization	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric *Partial Hospitalization* Facility	
Outpatient Services	$20 *copayment* per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital *Facility*	
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*	20 visits for chronic management conditions per *benefit period* 2 visits per *benefit period* for nonpreventive obesity services
OFFICE VISITS, CONSULTATIONS, TELEHEALTH AND VIRTUAL CARE			
Inpatient Consultations	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Outpatient Office Visit, Consultations, Clinic, and Telehealth Visits	$20 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 copayment per visit for all other professional providers	20% coinsurance after deductible	Includes in-person and telehealth visits.
Virtual *Care Visits delivered via the Capital BlueCross Virtual Care platform*	$10 copayment per visit	Not Covered	Service provided by a contracted vendor and delivered via the Capital BlueCross Virtual Care platform
ORTHOTIC DEVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Orthotic Supplier *Facility*	Foot orthotics are covered for all members for any reason
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care	Covered in full *deductible* waived	20% *coinsurance*, *deductible* waived for Pennsylvania mandated childhood immunizations	(includes physical examinations, childhood immunizations and tests)

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Adult Preventive Care	Covered in full *deductible* waived	20% *coinsurance* after *deductible*	(includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law) Preventive PSA Test age limit is 45 and older for males Preventive bone density test age limit 50 and older for females.
PRIVATE DUTY NURSING SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Prosthetic Supplier *Facility*	
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*

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
SUBSTANCE USE DISORDER SERVICES			
Detoxification – Inpatient	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
Rehabilitation – Inpatient	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
Rehabilitation – Outpatient	$20 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
SURGERY			
Outpatient Surgery Facility	Covered in full after *deductible* for *outpatient* surgical procedures performed at an *Ambulatory Surgical Facility*. Covered in full after *deductible*, for *outpatient* surgical procedures performed at an Acute Care Hospital facility.	50% *coinsurance* after *deductible* covered at an *Ambulatory Surgical Facility*. 50% *coinsurance* after *deductible* at an *Hospital Facility*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Professional Surgery Services including Anesthesia	Covered in full after *deductible*	20% *coinsurance* after *deductible*	(Includes Inpatient and Outpatient professional surgical services)
THERAPY SERVICES			
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)
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*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
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, services, devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Diagnostic Hearing Services	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Foot Care	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Refer to Foot Care benefit description.
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*	
Vision Care for Illness or Accidental Injury	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

COST-SHARING DESCRIPTIONS

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

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

Application of Cost Sharing

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

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

- Copayments
- Deductibles
- Coinsurance

In addition, you are responsible for any:

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

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

Copayment

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

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

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 (for example, laboratory tests). Also, some services result in separate charges for both the service and the use of the facility. This may result in more than one *copayment* being assessed for the covered service being provided to you.

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 we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on the *member's coverage*, there may be a *deductible* amount applicable only to *benefits* received for services provided by *in-network providers* and a separate *deductible* amount applicable only to *benefits* received for services provided by *out-of-network providers*.

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*, we 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 *in-network* and *out-of-network providers*.

*R*efer to the **Summary of Cost Sharing and Benefits** section to determine if any *deductibles* apply to your *coverage*.

Coinsurance

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

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

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

Out-of-Pocket Maximum

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

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

Benefit Period Maximum

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

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

Benefit Lifetime Maximum

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

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

Balance Billing Charges

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

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

- For *in-network providers*, the *allowable amount* for a *benefit* is set by the *provider's* contract with us. These contracts also include language whereby the *provider* agrees to accept the amount paid by us, minus any *cost-sharing amount* due from you, as payment in full.
- For *out-of-network providers*, the *allowable amount* for a *benefit* determines the maximum amount we will pay you for *benefits*. Since the *out-of-network provider* does not have a contract with us, the *provider* has not agreed to accept *the allowed amount* as payment in full. The *allowable amount* in these situations can be less than the *provider's* charge. Therefore, you are 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 us, or required by law, we will pay you for services performed by an *out-of-network provider.* You are responsible for paying the provider.

BENEFITS DESCRIPTIONS

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

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

Certain healthcare services require *preauthorization* by us or our designee. Please see the **Preauthorization Program** attachment to this *Benefits Booklet* for the list of services that require *preauthorization*.

Acute Care Hospital Room and Board and Associated Charges

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

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

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

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

Long-Term Acute Care Hospital

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

Acute Inpatient Rehabilitation

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

Allergy Services

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

Testing

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

Immunotherapy

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

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

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

Allergy Serums

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

Autism Spectrum Disorders

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 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 us*,* or the *contract holder's* Managed Behavioral Healthcare Organization*.* Review of the treatment plan will be required by us before authorization of services. Treatment plans will be reviewed every six 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 the following services (visit limits may apply when rendered to *members* aged 21 and older; refer to the **Summary of Cost-Sharing and Benefits** section 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, and 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 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 Services, Supplies and Education

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

Equipment, agents, and orthotics include the following:

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

Diabetes Education

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

Diagnostic Services

Diagnostic services are procedures ordered by a *physician* because of specific symptoms to determine a definitive condition or disease, not for screening purposes. *Benefits* for diagnostic services include, but are not limited to: radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening.

Laboratory Tests

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

In certain situations, an additional *cost-sharing amount* may be associated with a lab service performed by a *provider* that is not an independent laboratory. An independent laboratory is one that performs clinical pathology procedures and is not affiliated or associated with a *hospital, physician or facility provider*. For a list of independent laboratories, as well as how to access them, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *member 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 Positron Emission Tomography (PET Scan), Computerized Axial Tomography (CAT Scan), Magnetic Resonance Angiography (MRA), and Single Photon Emission Computed Tomography (SPECT Scan).

Dialysis Treatment

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

Durable Medical Equipment (DME) and Supplies

Durable medical equipment consists of items that meet these criteria:

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

- Reusable.
- Can withstand repeated use.

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

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

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

DME may be rented or purchased based on:

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

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

Except in circumstances of risk of disability or death, there are generally no *benefits* for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items.

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

Emergency and Urgent Care Services

Emergency Services

An *emergency service* is any healthcare service provided to 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 any one of the following:

- 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.
- 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 you are admitted as an *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient* consultation *copayment*.

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

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

Urgent Care Services

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

Enteral Nutrition

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

Benefits for enteral nutrition products are covered at standard *cost-sharing amounts* if the enteral nutrition product provides 50% or more of total nutritional intake.

Regardless of the percentage of 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 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 *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 healthcare *provider*. The exam generally includes a pelvic examination, a Pap smear, a breast examination, a rectal examination and a review of the patient's past health, menstrual cycle and childbearing history. *Benefits* for screening gynecological exams are covered under the **Preventive Care Services** section and are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Screening Papanicolaou Smear

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

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

Home Healthcare Services

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

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

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

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

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

Home Healthcare Visits Related to Mastectomies

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

Home Healthcare Visits Related to Maternity

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

Hospice Care

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

Residential Hospice Care involves palliative care provided in a *hospice* facility for the express or implied purpose of providing end-of-life care for the terminally ill patient who is unable to remain in the home and requires facility placement to provide for routine activities of daily living (ADLs) as well as specialized *hospice* care on a 24-hour-per-day basis.

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

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

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

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

Immunizations and Injections (Nonpreventive)

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

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

Infertility Services

Infertility is 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.

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), zygote intra-fallopian transfer (ZIFT), and artificial insemination are not covered.

Infusion Therapy

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

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

Benefits for infusion therapy include the procurement and preparation of the pharmaceuticals, biologicals and fluids; accompanying medications and solutions; supplies and equipment used to administer the infusions; and inpatient and outpatient care required to administer and monitor the infusions.

Interruption of Pregnancy

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

Mammograms

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

Screening Mammogram

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

Diagnostic Mammogram

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

Maternity Services

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

Prenatal Services

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

Delivery

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

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

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

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

Postpartum Services

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

Medical Transport

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

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pickup is not accessible by land, and the transport is to an acute care hospital (whether for initial transport or subsequent transfer to another facility for special care).

Emergency Ambulance

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

Nonemergency Ambulance

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

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

Mental Healthcare Services

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

Inpatient Services

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

Partial Hospitalization

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

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

Outpatient Services

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

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

Newborn Care

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

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

Nutrition Therapy (Counseling and Education)

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

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

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

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

Office Visits, Consultations, Telehealth and Virtual Care

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

- *Telehealth* (audio and video)
- Provider office
- Hospital
- Retail facility

Visits

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

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.

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

Consultations

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

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

Coverage for consultations does not include the following:

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

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

Retail Clinic Services

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

Telehealth

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

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

Telehealth coverage does not include the following:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results
- Nurse call centers/advice centers
- Services involving remote invasive treatment and/or diagnostic testing
- Group counseling

Capital BlueCross Virtual Care

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

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

Capital BlueCross Virtual Care benefits are limited to the following *medically necessary* services:

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

Capital BlueCross Virtual Care coverage does not include:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results.
- Nurse call centers/advice centers.
- Services involving remote invasive treatment and/or diagnostic testing.
- Group counseling.

For information on accessing Capital BlueCross Virtual Care, visit CapitalBlueCross.com.

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

Pediatric

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

Adult

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

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** attachment due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. We follow guidelines set by the CDC 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*.

Prosthetic Appliances

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

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

Wigs are covered prosthetics in certain cases and may be subject to a *benefit lifetime maximum*. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered. Glasses, cataract lenses, contact lenses, and scleral shells prescribed after cataract or intra-ocular *surgery* **without** a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

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

Skilled Nursing Facility

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

Substance Use Disorder Services

Detoxification – Inpatient

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

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

Rehabilitation

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

Inpatient — *Benefits* for *inpatient substance use disorder* rehabilitation include: bed, board and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to you as an *inpatient* for *substance use disorder* 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)*, *partial hospitalization* or through *medication assisted treatment (MAT)*.

Surgery

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

Surgical Procedure

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

Outpatient Surgery

Outpatient surgery may be performed in an acute care *hospital* or *ambulatory surgical facility*. *Benefits* for *ambulatory surgical facilities* include those *outpatient surgeries* that, in the judgment of the provider,

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

Anesthesia Related to Surgery

Benefits for the administration of anesthesia related to *surgery* include services ordered by the attending *professional provider* and rendered by a *professional provider*, including the operating *physicians* under certain circumstances, but other than the assistant at *surgery*, or the attending *physician*.

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

Mastectomy and Related Services

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

Oral and Orthognathic Surgery

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

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

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

Other Surgeries

Benefits for other specialized surgical procedures include the following services:

- Routine neonatal circumcisions.

- Sterilization procedures.

Therapy Services

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

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

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

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 FDA guidelines.

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

Manipulation Therapy

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

Benefits include maintenance manipulation therapy for chronic pain management.

Occupational Therapy

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

Benefits for occupational therapy include rehabilitative and habilitative services.

Physical Therapy

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

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

Benefits for physical therapy include rehabilitative and habilitative services.

Radiation Therapy

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

Respiratory/Pulmonary Rehabilitation Therapy

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

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

Maintenance respiratory and pulmonary therapy is not covered.

Speech Therapy

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

Benefits for speech therapy include rehabilitative and habilitative services.

Transplant Services

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

Pre-Transplant Evaluation

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

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

Acquisition and Transplantation

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

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

- If we cover only the transplant recipient, we provide *benefits* for the recipient and for the donor, but only to the extent that donor benefits are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's coverage.

If we cover the transplant recipient and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

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

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

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

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

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

Post-Transplant Services

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

Blue Distinction Centers for Transplant (BDCT)

Blue Distinction Centers for Transplant are a cooperative effort of the BlueCross and/or BlueShield 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 you and one support companion. Items that are not covered include, but are not limited to, alcohol, tobacco, car rental, entertainment, expenses for persons other than you and your 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 Services

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

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

Foot Care

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

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

Orthodontic Treatment of Congenital Cleft Palates

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

Routine Costs Associated with Approved Clinical Trials

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

Vision Care for Illness or Accidental Injury

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

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

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

EXCLUSIONS

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

Anesthesia	• Anesthesia when administered by the assistant to the operating *physician* or the attending *physician*
Blood and Administration	• Prophylactic blood, cord blood or bone marrow storage to be used in the event of an accident or unforeseen *surgery* or transplant
Clinical Trials	• Services or supplies that we consider to be *investigational*, except routine costs associated with a*pproved clinical trials* Routine costs for clinical trials do not include any of the following and are therefore excluded from *coverage*: • The investigational drug, biological product, device, medical treatment, or procedure itself • The services and supplies provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient • The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial • Your travel expenses
Convenience	• Personal hygiene, comfort, 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) • Radios and televisions • Beauty or barber shop services • Incontinence supplies, deodorants • Guest trays, chairlifts, elevators, or any other modification to real or personal property, whether or not recommended by a *provider* • Spa or health club memberships • Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments such as premiums, which entitle those enrolled to services; repairs; or replacement of devices, equipment, or parts without charge or at a reduced charge
Cosmetic Surgery	• Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the

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

	adhesive removers, face masks, replacement batteries or alcohol pads • Supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices
Education	• Services provided at unapproved sites, for a *member's* individualized education program (IEP), or as part of a *member's* education, except as may be required by statue or explicit legal requirement
Eligibility	• Services incurred prior to your *effective date of coverage* • Services incurred after your *coverage* termination date except as provided for in this *Benefits Booklet*
Eligible Provider	• Services not billed and either performed by, or under the supervision of, an eligible *provider* • Services rendered by a *provider* who is a member of your *immediate family* • Telephone and electronic consultations, including *virtual services*, between you and a *provider*, except as otherwise provided in this *Benefits Booklet* • 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*
Experimental or Investigational	• Services or supplies we consider to be *investigational,* except where otherwise required by law
Food/ Nutritional Support	• Enteral nutrition due to lactose intolerance or other milk allergies • Blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Benefits Booklet* • All other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Benefits Booklet*
Foot Care	• Routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except *surgery* for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints
Genetic Testing	• At-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic

	testing performed primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*
Hearing Aids	• Hearing aids, examinations for the prescription or fitting of hearing aids, and all related services
Immunizations	• Immunizations required for travel or employment except as required by law
Infertility Services	• Donor services related to assisted fertilization • Procedures to reverse sterilization • Any treatment or procedure leading to or in connection with assisted fertilization, such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and artificial insemination except as provided in this *Benefits Booklet* • For *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
Interruption of Pregnancy/Abortion	• For elective terminations of pregnancy
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by our Medical Director(s) or his/her designee(s)
Medicare	• Items or services paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws for any *member* who is enrolled in *Medicare*. This exclusion does not apply to the extent the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare*.
Medications	• All prescription and *over-the-counter* drugs dispensed by a pharmacy or *provider* for your *outpatient* use, whether or not billed by a *facility provider*, except for allergy serums, mandated pharmacological agents used for controlling blood sugar, FDA-approved drugs for the treatment of substance use disorder, and where otherwise required by law • All prescription and *over-the-counter* drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan that we approved
Military Services	• Services received by veterans and active military personnel at facilities operated by the U.S. Department of Veterans Affairs or

	by the Department of Defense, unless payment is required by law
Miscellaneous	• Care of conditions that federal, state, or local law requires to be treated in a public facility • Any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • Services you receive from a dental or medical department maintained by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar person or group • Charges for: failure to keep a scheduled appointment with a *provider*, completion of a claim or insurance form, obtaining copies of medical records, your decision to cancel a *surgery*, or hospital-mandated on-call service • Charges that exceed the *allowable amount*, except as otherwise provided for in this *Benefits Booklet* • *Cost-sharing amounts* you must pay as outlined in this *Benefits Booklet* • Autopsies or any other services rendered after a *member's* death • Any services related to or rendered in connection with a noncovered service, including but not limited to anesthesia and diagnostic services • Any other service or treatment, except as provided in this *Benefits Booklet*
Motor Vehicle Accident	• Cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy
Oral Surgery	• Oral *surgery* except as specifically provided in this *Benefits Booklet*
Prosthetics	• Prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device • Wigs and other items intended to replace hair loss due to male or female pattern baldness
Physical Exams	• Routine examination, counseling services, testing, screening, immunization, treatment or preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to: pre-marital examinations; employment or occupational screenings; or physicals for college, camp, sports, or travel

Sexual Dysfunction	• Treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury
Sports Medicine	• Sports medicine treatment or equipment intended primarily to enhance athletic performance
Surgery	• All types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present
Therapy Services	• For acupuncture • Biofeedback therapy • Cognitive rehabilitation therapy, except when provided as 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) • Maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law • Occupational therapy or physical therapy for work hardening, vocational and prevocational assessment and training, and functional capacity evaluations, as well as this therapy's use towards enhancement of athletic skills or activities • All rehabilitative therapy, other than as described in the *Benefits Booklet*, including but not limited to play, music, hippotherapy, and recreational therapy
Temporomandibular Joint Syndrome	• 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 or treatment of TMJ caused by physical trauma resulting from an accident • Intra-oral reversible prosthetic devices or appliances regardless of the cause of TMJ
Transplant	• Services related to organ donation where you serve as an organ donor to a nonmember • Transplant services where human organs were sold rather than donated and for devices functioning as total artificial organs that are not approved by the FDA
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this *Benefits Booklet*
Vision Care	• Routine eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including

	but not limited to refractive lenses prescribed for use with an intra-ocular lens transplant • Routine vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses. • Surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy, and refractive keratoplasty
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared
Weight Loss	• *Inpatient* stays to bring about nonsurgical weight reduction
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy or coverage, or the applicable law.

MEDICAL CLINICAL MANAGEMENT PROGRAMS

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

Clinical Management programs include:

- Utilization Management
- Population Health Management
- Quality Improvement

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

Utilization Management

The Utilization Management program is a primary resource to identify *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

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

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

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

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

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

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

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

Investigational Treatment Review

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

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

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

Preauthorization

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

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

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

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

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

A *preauthorization* decision is generally issued within 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 our experienced registered nurses and board-certified physicians who evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in *inpatient* settings (acute care hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals). In addition, the program is designed to facilitate identification and referral of *members* to other Clinical Management Programs, such as Population Health 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 day of receiving all necessary information.

Discharge Planning – Discharge planning is performed by concurrent review nurses who communicate with hospital staff 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

Our 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 we receive a claim for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred any of the following ways:

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

We issue retrospective review decisions generally within **30** calendar days of receiving all necessary information.

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

Population Health Management

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

Care Management

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

Programs include, but are not limited to the following:

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

Complex Case Management

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

- With complex medical needs.
- At risk for future adverse health events.

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

Chronic Condition/Disease Management

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

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

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

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

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

Maternity Management

We offer a comprehensive Maternity Management program that provides education, care coordination, materials and support to pregnant women.

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

Using a custom predictive modeling tool, pregnant members are stratified into high and low-risk categories, as follows:

- **Individuals stratified as high risk** receive direct telephone outreach from a nurse experienced in all phases of pregnancy and deliver, including high-risk labor and delivery, newborn care and post-partum care.
- **Individuals stratified as low risk** receive an automated outbound call that offers health education information during each trimester of their pregnancy, as well as a follow up post-partum call. Members may request to be warm transferred to our clinical staff or request a call back from a clinician at any time.

Oncology Case Management

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

Transitions of Care

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

Transplant Case Management

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

Health Education and Wellness

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

Quality Improvement Program

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

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

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

How We Evaluate New Technology

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

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, *specialists* and professionals with expertise in the technology, and government agencies such as the

FDA, the National Institutes of Health, and the CDC. The five key criteria used by the Committee to evaluate new technology are:

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

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

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

Alternative Treatment Plans

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

If the *contract holder* elects to provide alternative *benefits* 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

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

Termination of Group Contract

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

Termination of Coverage for Members

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

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

- *Subscriber* – *Coverage* ends on the date a *subscriber* is no longer employed by, or 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 the *dependent* spouse ceases to be eligible under this *coverage*.
- Child – *Coverage* of a child ends on the date the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child – *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* disabled child.

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

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

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

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

CONTINUATION OF COVERAGE AFTER TERMINATION

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

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

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA* 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 the following:

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

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

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

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

Coverage for Medicare-Eligible Members

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

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

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

Coverage for Totally Disabled Members

Benefits will be furnished to a totally disabled *subscriber* or a totally disabled *dependent* for services **directly related** to the condition that caused this total disability and for no other condition, illness, disease, or injury if the *subscriber* or the *dependent* is totally disabled on the date *coverage* is terminated.

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

- The individual is unable to perform the substantial and material duties of his/her regular occupation and is not in fact engaged in any occupation for wage or profit.
- If the individual does not usually engage in any occupation for wage or profit, the *member* is substantially unable to engage in the normal activities of an individual of the same age and sex.

If an eligible *member* meets the definition of totally disabled, extended disability *benefits* are provided, based on whichever occurs first:

- Up to a maximum period of 12 consecutive months.
- Until the maximum amount of benefits has been paid.
- Until the total disability ends.
- Until the *member* becomes covered, without limitation as to the disabling condition, under any other coverage.

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

APPLYING FOR COVERAGE FOR TOTALLY DISABLED *MEMBERS* IS THE *MEMBER'S* RESPONSIBILITY.

CLAIMS REIMBURSEMENT FOR MEDICAL BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for healthcare services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which *we* receive a claim for *benefits* is dependent upon the type of *provider* from which you receive services. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

In-Network Providers

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

Out-of-Network Providers

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

Out-of-Area Providers

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

Allowable Amount

For *professional providers* and *facility providers*, we base the *benefit* payment amount 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 your *cost-sharing amount* obligations.

Filing a Claim

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

Obtain a copy of this claim form at CapitalBlueCross.com or by calling Member Services at the number found on the back of your *member ID card*. Your claim will process more quickly when this form is

used. A separate claim form must be completed for each person enrolled for *coverage* who received medical services.

A Special Note about Medical Records

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

Where to Submit Medical Claims

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

Capital BlueCross
PO Box 211457
Eagan, MN 55121

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

Out-of-Country Claims

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

Inpatient Hospital Claims

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

Professional Provider Claims

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

International Claim Form

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

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

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

Time Frames Applicable to Medical Claims

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

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

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

Special Time Frames Applicable to "Urgent Care" Claims

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

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

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

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

Special Time Frames Applicable to "Concurrent Care" Claims

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

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

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

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

Coordination of Benefits (COB)

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

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

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

Definitions Unique to Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, *preauthorization*, and preferred provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

a. Nondependent or Dependent.

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

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

b. Child Covered Under More Than One Plan.

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

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

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

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

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

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or

- If there is no court decree allocating responsibility for the child's healthcare expenses or coverage, the order of benefits for the child is as follows:

  ◊ The Plan covering the Custodial Parent;

  ◊ The Plan covering the spouse of the Custodial Parent;

  ◊ The Plan covering the noncustodial parent; and then

  ◊ The Plan covering the spouse of the noncustodial parent.

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

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

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

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

d. *COBRA* or State Continuation Coverage.

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

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

e. Longer or Shorter Length of Coverage.

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

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

Effect on the Benefits of This Coverage

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

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

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

Right to Receive and Release Needed Information

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

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

Facility of Payment

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

Right of Recovery

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

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

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

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

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

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

Disability

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

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

End Stage Renal Disease (ESRD)

The *group contract* will remain primary for the first 30 months of a *member's* eligibility or entitlement to *Medicare* due to ESRD, 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.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to *providers* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made in Error

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

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the *benefits* under coverage.

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

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

If you disagree with an adverse benefit determination with respect to *benefits* available under this *coverage* 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 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 you disagree with *an* adverse benefit determination, you may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, you may appoint a representative to act on your behalf as more fully discussed below. The appeal should include the reason(s) you disagree with the adverse benefit determination. The appeal must be received by us within 180 days after you received notice of the adverse benefit determination. Your appeal must be sent to:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

You may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, we will provide you with a full and fair internal review. We will provide you, free of charge, (1) with any new or additional evidence considered or relied upon, or generated in connection with the claim as well as (2) any new or additional rationale which may be the basis of a final internal adverse appeal determination as soon as possible and prior to issuing a decision on the appeal in order for you to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, we will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination. You may contact us at **800.962.2242** (TTY: **711**) to receive information on the internal review process and to receive

additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al* ***800.962.2242****.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

External Appeal Process

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on the our requirements for *medical necessity*, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission).

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

The IRO must notify you of its decision on the appeal in writing within 45 days from receipt of the request for external review.

*Member*s of a group health plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) may have a right to bring a civil action under Section 502(a) of ERISA.

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit determinations involving "urgent care decisions".

Expedited Internal Appeal Process for Claims Involving Urgent Care. You may seek expedited internal review of the determination of a claim involving urgent care by contacting us at the telephone number above. We will respond with a determination within 72 hours. You may also request an expedited external appeal simultaneously with the request for an expedited internal appeal. If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

Expedited External Appeal Process for Claims Involving Urgent Care. You may request an expedited external review of the Final Internal Adverse Benefit Determination involving an urgent care claim as defined above or where the decision concerns an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility. To request an expedited external appeal review of such a Final Internal Adverse Benefit Determination, you or your physician must contact us at the telephone number above and may provide a physician's certification indicating your claim is urgent in accordance with the definition above. Upon receipt of a request for an expedited external review, we will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a determination within 72 hours of receipt of the request.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit

Determination involving an urgent care claim as defined above and a concurrent care situation as defined below.

How to Appeal a Concurrent Care Claim Determination

Special rules apply to adverse benefit determinations involving "concurrent care decisions".

If we approved an ongoing course of treatment to be provided over a period of time or number of treatments, you have the right to an expedited appeal of any reduction or termination of that course of treatment by us before the end of such previously approved period of time or number of treatments. We will notify you of our decision to reduce or terminate your course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain an appeal decision before your *benefits* are reduced or terminated.

If you wish to appeal you must call Member Services at **800.962.2242** (TTY: **711**). We will notify you of the outcome of the appeal via telephone or facsimile not later than 72 hours after we receive the appeal. We will defer any reduction or termination of your ongoing course of treatment until a decision is reached on the appeal.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit Determination involving an urgent care claim as defined above and a concurrent care situation.

Designating an Individual to Act on Your Behalf

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

To designate an individual to serve as your "authorized representative" or "designee" you must complete, sign, date, and return *Capital's* Member Authorization Form. You may request this form from our Member Services department at **800.962.2242** (TTY: **711**).

We communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

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

- An insured arrangement, we are the named fiduciary.
- A self-funded or "self-insured" arrangement, either the *plan sponsor* of the self-funded group health plan or we may serve as the named fiduciary.

The named fiduciary, with respect to any specific appeal, has full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any *member* is entitled to receive *benefits* under the terms of the group health plan. Any construction of terms of any plan document and any determination of fact adopted by the named fiduciary will be final and legally binding on all parties, subject to review only if such construction or determination is arbitrary, or capricious, or otherwise an abuse of discretion.

GENERAL PROVISIONS

Additional Services

From time to time, we, in conjunction with contracted companies, may offer other programs under this *coverage* to assist *members* in obtaining appropriate care and services.

Discounts and Incentives

We may also make available to our *members* access to health and wellness related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

These discount and incentive programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by us separately or independently from the *group contract*. There is no additional charge to *members* for accessing these discount and incentive programs. Contact the Plan Administrator for information on these programs.

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *Capital coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between *Capital* and *contract holder* without the consent or concurrence of the *members*. By electing *Capital* or accepting *Capital benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees with regard to *coverages* under this *contract*. Changes in *coverage* for *benefits* or changes in taxes or fees may result in upward adjustments in cost of *coverage* to reflect such changes. Such adjustments may occur on the earlier of either the *group contract* renewal date or the date such changes are required by law.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.*

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in medical policy, *preauthorization* requirements, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

In the future, should terms and conditions associated with this coverage change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Conformity with Statutes

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or nonuse of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular healthcare *provider*. If the *member's in-network provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Preferred Provider Organization ("PPO") program that is administered by *Capital* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. If there is a conflict of terms between the *policy/contract* and the *Benefits Booklet*, the terms of the *policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

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 *Benefits Booklet*, shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Member ID Cards

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

Member ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *member ID cards* must be returned to us within 31 days of the end of a *member's* coverage. *Member ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Proof of Loss

Claims for proof of loss must be submitted within 12 months after completion of the covered services to receive benefits from *Capital*. *Capital* will not be liable under this *group contract* unless proper and prompt notice is furnished to *Capital* that covered services have been rendered to a *member*. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the **Schedule of Cost Sharing** section. 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 and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to *Capital* within the time specified will not reduce any benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will *Capital* be required to accept the proof of loss more than 12 months after benefits are provided, except if the person lacks legal capacity.

Time of Payment of Claims

Claim payment for *benefits* payable under this agreement will be processed immediately upon receipt of proper proof of loss.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost-sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Payment Recoupment

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* that should not have been paid by *Capital.*

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain the physician-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Capital* and healthcare *providers* (including PCPs and other *physicians*) is an independent contractor relationship. Healthcare *providers* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital*, and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital 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 an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Public Health Emergency

In the event that *Capital* reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, *Capital* may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, *member* cost share, provisions related to the use of an *in-network provider*, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination and Autopsy

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

ADDITIONAL INFORMATION

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

- A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Capital*.
- The procedures adopted by *Capital* to protect the confidentiality of medical records and other *member* information.
- A description of the credentialing process for *in-network providers*.
- A list of the *in-network providers* affiliated with in-network *hospitals*.
- If *prescription drugs* are provided as a *benefit* under this *coverage,* whether a specifically identified drug is included or excluded from this *coverage*.
- A description of the process by which an *in-network provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Capital* drug *formulary* for *prescription drugs* or biologicals when the *formulary's* equivalent has been ineffective in the treatment of the *member's* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member's* case, if *prescription drugs* are provided as a *benefit* under the *member's coverage*.
- A description of the procedures followed by *Capital* to make decisions about the nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by *Capital* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network provider*.
- A 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

You may also fax your requests to **717.541.6915** or by accessing CapitalBlueCross.com, or an email can be sent to Member Services.

You may inform us of your dissatisfaction with the quality of care or service you may have received by writing to the address above or by faxing us at the number above. You can also call Member Services to register the dissatisfaction (please refer to the **How to Contact Us** section for contact information).

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 HEALTHCARE*		
For Routine History and Physical Examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer chemoprevention • Contraceptive methods/counseling[1] • Folic Acid (childbearing age)	• Hormone Replacement Therapy (HRT) – risk vs. benefits • Urinary Incontinence Assessment	At least annually
Men and Women		
• Aspirin prophylaxis (high risk) • Calcium/vitamin D intake • Drug use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity/Exercise • Seat Belt use • Statin Medication (high risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) test	Testing every 2 years for women age 19-64 at increased risk for Osteoporosis. Once every 2 years for women over age 65 and older.
BRCA screening/genetic counseling/testing	For women at risk, including those not previously diagnosed with BRCA-related cancer but who have a personal or family history of cancer.
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 healthcare provider. Suggested testing is every 1-3 years.
Domestic/Interpersonal/Partner Violence screening/counseling	At least annually for women age 19 and older; provide or refer services as determined by your healthcare provider.
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 use 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 healthcare 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 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 age 18-79. 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: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
Obesity/Overweight + Cardiovascular Risk Factor combination	Age 19 and older for high risk adults: 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**	
Haemophilus Influenza type b (Hib)	Age 19 and older Based on individual risk or healthcare provider recommendation: one or three doses
Hepatitis A (HepA)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Hepatitis B (HepB)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Human Papillomavirus (9vHPV)	Age 19-26: Two or three doses, depending on age at series initiation.
Influenza	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 healthcare provider recommendation, one or two doses.
Meningococcal (conjugate) (MenACWY)	Age 19 and older Based on individual risk or healthcare 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 healthcare provider recommendation: Two or three doses depending on indication, then booster every 2-3 years if risk remain
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose (high risk; 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) Age 65 and older. Based on individual risk or healthcare provider recommendation: One dose at least 5 years after PPSV23
Tetanus/diphtheria/pertussis (Td or Tdap)	Age 19 and older One dose of Tdap, then Td or Tdap 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 located on the Capital BlueCross web site at capbluecross.com.

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)
- Depression screening (prenatal/ postpartum)
- 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 screening
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Asymptomatic Urine Bacteria Screening
- Other preventive services may be available as determined by your healthcare provider

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

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years [annually].

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (thru 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (thru 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, use/education
  - 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 use screening/ counseling																				✔	✔
Anemia screening			✔	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	At least annually for adolescents of childbearing age, 11 years of age and older; provide or refer services as determined by your healthcare provider.																				
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 7 and 9																				
Hearing test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
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 or younger for at risk: at every well-child visit. Confirm HBP outside office by Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV screening/risk assessment	Annually beginning at 11 years																				
HIV test	Routine one-time testing between 15-18 years old. If indicated by high risk assessment testing may begin earlier Periodic repeat testing (at least annually) of all high risk children.																				
Lead screening test/risk assessment	Screening Test: 12 to 24 months (at risk)[2]; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid screening/risk assessment				✔		✔		✔		✔				✔	✔	✔	✔	✔	✔		
Lipid test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal depression screening	By 1 month, 2 month, 4 month and 6 months																				
Newborn bilirubin screening	✔																				
Newborn blood screen *(as mandated by the PA Department of Health)*	✔																				
Newborn critical congenital heart defect screening	✔																				
	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
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
Haemophilus influenza type b (Hib)	2 months, 4 months, 6 months (4 dose), 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk, as indicated
Hepatitis A (HepA)	12–23 months (2 doses) (catch-up through age 18)
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Human papillomavirus HPV	11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for those 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 12)
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)	16–18 years for individuals not at high risk; 10–18 years for those 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) for those at high risk.
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)
Rotavirus (RV)	2 months, 4 months, 6 months (3 doses) 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] Refer to the most recent Formulary located 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 an in-network provider (including a BlueCard facility participating provider providing inpatient services), the in-network provider will be responsible for obtaining the preauthorization. If members use an out-of-network provider or a BlueCard participating provider providing non-inpatient services, the out-of-network 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 our Utilization Management Department toll-free at 1-800-730-7219 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. In-network providers and members have full access to our medical policies and may request preauthorization for experimental or investigational services/items if there are unique member circumstances.

We only pay for services and items that are considered medically necessary. Providers and members can reference our medical policies for questions regarding medical necessity. Final determination of coverage is subject to the member's benefits and eligibility on the date of service.

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.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* 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*.

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. Capital may from time to time remove preauthorization requirements for benefits under certain dollar thresholds. For a listing of services currently requiring *preauthorization*, including any threshold requirements members and providers may consult CapitalBlueCross.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 use disorder)	*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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	
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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com
Select Cardiac Services		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at CapitalBlueCross.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 *non participating 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*.

Applicable Group Numbers

PPO Plan 276

July, 2021

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Colonial Intermediate Unit #20	00521915

APPENDIX C – PROFESSIONAL & ADMIN

Colonial Intermediate Unit 20

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 C 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

00521915

PPO

GROUP PREFERRED PROVIDER BENEFITS BOOKLET

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 Member Services 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).

ગુજરાતીમા 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

WELCOME

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

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

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

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

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

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

Let's Get Started

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

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

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

IMPORTANT NOTICES

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

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

HOW TO CONTACT US

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

Online

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

Member Services

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

Call	**800.962.2242 or TTY users, 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital BlueCross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a CapitalBlue Connect Health and Wellness Center	Go to **CapitalBlueStore.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **The Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025

DEFINITIONS

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

Allowable Amount: The maximum charge or payment level that we reimburse for *benefits* provided to you under your *coverage*.

- For *in-network providers*, the allowable amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
- For *out-of-network providers*, the allowable amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Benefits Booklet*.

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

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

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 meets the following criteria:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health (NIH)
    2. Centers for Disease Control and Prevention (CDC)
    3. Agency for Healthcare Research and Quality (AHRQ)
    4. Centers for Medicare and Medicaid Services (CMS)
    5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
    6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants.
    7. The VA, the DOD, or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
        a) The Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the NIH, and

b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug that is exempt from having such an investigational new drug application.

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

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

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

Birth Defect: Also known as congenital anomalies, congenital disorders or congenital 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 licensed *facility provider* primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

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

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

Coinsurance: The percentage of the *allowable amount* that you are responsible to pay under the group contract. *Coinsurance* percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

Copayment (Copay): The fixed dollar amount that you must pay for certain *benefits*. You may be required to pay copayments directly to the *provider* at the time of service or purchase. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

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

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

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

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

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

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

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

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

- an urban search and rescue EMS service.

A vehicle or service that provides emergency medical services outside of a healthcare facility.

Emergency Services: Any healthcare services provided to a *member* after the 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 any of the following:

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

Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

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

Facility Provider: Includes the following:

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

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

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

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

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

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

Group 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 *Benefits Booklet*, between the *contract holder* and us for the administration of *benefits*.

Group Effective Date: The date 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 us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for coverage.

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.

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

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

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

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

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

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

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.

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

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

Inpatient: When you are admitted as a patient and 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 a room and board charge is made. This term may also describe the services rendered to you while admitted.

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

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

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

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

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

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

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 hospitalization (average 25 days) and who would require high-intensity services. LTACHs are a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, the Pennsylvania Department of Health licenses LTACHs as an acute care facility.

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

Medical Necessity (Medically Necessary): Means the following

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

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

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

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

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

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

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

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

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

Out-of-Pocket Maximum: A specified dollar amount of *deductible*, *copaymen*t, and *coinsurance* expense incurred by you or your family for covered services in a *benefit period*. After you have paid this amount, you are no longer required to pay any portion of the *allowable amount* for *benefits* during the remainder of that *benefit period*. The amount of, and types of cost-sharing applied to, the out-of-pocket maximum is described in the **Summary of Cost-Sharing and Benefits** section.

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

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

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 us or our designee that results from a process used to determine your eligibility at the time of the request, *benefit* coverage and the *medical necessity* of the proposed medical services before delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this *Benefits Booklet*.

Professional Provider: Includes any of the following:

- 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 *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

Provider Incentive: An additional amount of compensation paid to a healthcare *provider* by a 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 licensed facility *provider* primarily engaged in providing diagnostic and therapeutic services for mental *healthcare*. Such services are provided by or under the supervision of an organized staff of *physicians*.

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 qualify surgery, in the absence of bodily *functional impairment*, as being *reconstructive surgery*.

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

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

Residential Treatment Facility (RTF): A licensed nonhospital *facility provider* that provides 24-hour level of care and 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 registered nurse 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 we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

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

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

- The services and supplies required for the diagnosis or treatment of complications.

Service Area: The 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.

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

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

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

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

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

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

Substance Use Disorder Treatment Facility: A *provider* licensed and approved by the state in which it provides healthcare services, or as otherwise approved by us 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 healthcare services are received.

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

Telehealth: *Medically necessary* services provided to you by a *provider* in which the method of care delivery involves interaction between you and the *provider* using 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.

HOW TO ACCESS BENEFITS

Member ID Card

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

You should show your *member ID card* and any other ID cards for other coverage each time you seek medical services. *Providers* use this information from your *member ID card* to submit claims for processing and payment.

IMPORTANT INFORMATION ABOUT YOUR MEMBER ID CARD:

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

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

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

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

Obtaining Benefits for Healthcare Services

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

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

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

Services Provided by In-Network Providers

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

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

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

Services Provided by Out-of-Network Providers

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

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

Because *out-of-network providers* are not obligated to accept our payment as payment in full, you may be responsible for the difference between the *provider's* charge for that service and the amount we 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 we pay for the service and what the *provider* charged. In addition, unless otherwise required by law, all payments are made directly to the *subscriber*; and then you are responsible for reimbursing the *provider*. Additional information on balance billing charges can be found in the **Cost-Sharing Descriptions** section.

Emergency Services

An *emergency service* is any healthcare service provided to you 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 any of the following:

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

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

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

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

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

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

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

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

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

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

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

Special Cases: Value-Based Programs

BlueCard Program

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

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

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

Blue Cross Blue Shield Global® Core

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

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

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the cost-sharing amounts (deductibles, coinsurance, etc.). In such cases, the hospital will submit the claims to the service center to begin claims processing.

However, if you pay in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. **You must contact us to obtain precertification for nonemergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

SUMMARY OF COST SHARING AND BENEFITS

The following table provides a summary of the applicable *cost-sharing amounts* and *benefits* provided under this *coverage*.

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

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

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DEDUCTIBLE (PER BENEFIT PERIOD)			
Deductible (Per Benefit Period)	$825 per *member* $1,650 per family	$1,650 per *member* $3,300 per family	Copayments and coinsurance do not apply to deductible.
OUT-OF-POCKET MAXIMUM			
Out-of-Pocket Maximum When you reach your out-of-pocket maximum, we pay all subsequent claims during the remainder of the benefit period at 100% of the allowable amount, except that coinsurance continues to apply for out-of-network facility providers.	$4,275 per member $8,550 per family The in-network out-of-pocket maximum includes all deductible, copayments, and coinsurance for benefits received from in-network providers.	$2,000 per member $4,000 per family The out-of-network out-of-pocket maximum includes only coinsurance for out-of-network professional providers.	The following expenses do not apply to either the in-network or out-of-network out-of-pocket maximum: • Expenses incurred for payment of a benefit after any applicable benefit period maximum has been exhausted The following expenses do not apply to the out-of-network out-of-pocket maximum: • Deductible • Copayments • Facility provider Coinsurance; and • Charges exceeding the allowable amount

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
ACUTE CARE HOSPITAL ROOM AND 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 SERVICES, SUPPLIES AND EDUCATION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
DIAGNOSTIC SERVICES			
Laboratory Tests	Covered in Full after *deductible* when performed at an independent laboratory or drawn at a physician's office and sent to an independent laboratory. Covered in Full after *deductible* after deductible, when performed at a facility/hospital owned laboratory	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospital* Laboratory *Facility* 50% *coinsurance* after *deductible* at an *Freestanding Diagnostic Facility*	
All other Medical Tests	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Radiology Services (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* Not Covered for *Freestanding Dialysis Facilities*	
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Durable Medical Equipment Supplier Facility	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services	$125 *copayment* per visit, *copayment* waived if admitted **Note: Your cost share is the same regardless of whether an in-network provider or an out-of-network provider delivers the emergency services.** (Only one ER copayment will apply for the administration of the rabies vaccine series at the initial visit/injection.)		**Refer to Emergency and Urgent Care Services benefit description for more details** Limitation within 72 hours and all follow up

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Urgent Care Services	$50 *copayment* per visit	20% *coinsurance*after *deductible*	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
ENTERAL NUTRITION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Enteral nutrition products for certain therapeutic treatments are not subject to deductible. See Benefit Descriptions section for details.
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 HEALTHCARE SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Home Health Care Agency Facility*	90 visits per *benefit period*

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
HOSPICE CARE			
Benefits (includes *Residential Hospice Care*)	Inpatient hospice Covered in full after *deductible* Outpatient hospice Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospice Facility*	
IMMUNIZATIONS AND INJECTIONS (NONPREVENTIVE)			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
INFERTILITY SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
INFUSION 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*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
MATERNITY SERVICES			
Benefits for Prenatal Services, Delivery and Postpartum Services	Covered in full after *deductible* for facility services Covered in full after *deductible* for professional services	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Birthing Facility*	
MEDICAL TRANSPORT			
Emergency Ambulance	Covered in full *deductible* waived **Note: Cost share is the same regardless of whether the emergency services are provided by an in-network *provider* or an *out-of-network provider*.**		
Nonemergency Ambulance	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
MENTAL HEALTHCARE SERVICES			
Inpatient Services	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital Facility	
Partial Hospitalization	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric *Partial Hospitalization* Facility	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
Outpatient Services	$25 *copayment* per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $40 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital *Facility*	
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*	20 visits for chronic management conditions per *benefit period* 2 visits per *benefit period* for nonpreventive obesity services
OFFICE VISITS, CONSULTATIONS, TELEHEALTH AND VIRTUAL CARE			
Inpatient Consultations	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Outpatient Office Visit, Consultations, Clinic, and Telehealth Visits	$25 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $40 copayment per visit for all other professional providers	20% coinsurance after deductible	Includes in-person and telehealth visits.
Virtual *Care Visits delivered via the Capital BlueCross Virtual Care platform*	$10 *copayment* per visit	Not Covered	Service provided by a contracted vendor and delivered via the Capital BlueCross Virtual Care platform

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
ORTHOTIC DEVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Orthotic Supplier Facility	Foot orthotics are covered for all members for any reason
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care	Covered in full *deductible* waived	20% *coinsurance*, *deductible* waived for Pennsylvania mandated childhood immunizations	(includes physical examinations, childhood immunizations and tests)
Adult Preventive Care	Covered in full *deductible* waived	20% *coinsurance* after *deductible*	(includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law) Preventive PSA Test age limit is 45 and older for males Preventive bone density test age limit 50 and older for females.
PRIVATE DUTY NURSING SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Prosthetic Supplier Facility	
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* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
Rehabilitation – Inpatient	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Rehabilitation – Outpatient	$25 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $40 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
SURGERY			
Outpatient Surgery Facility	Covered in full after *deductible*, for *outpatient* surgical procedures performed at an *Ambulatory Surgical Facility*. Covered in full after *deductible*, for *outpatient* surgical procedures performed at an Acute Care Hospital facility.	50% *coinsurance* after *deductible* covered at an *Ambulatory Surgical Facility*. 50% *coinsurance* after *deductible* at an *Hospital Facility*	
Professional Surgery Services including Anesthesia	Covered in full after *deductible*	20% *coinsurance* after *deductible*	(Includes Inpatient and Outpatient professional surgical services)
THERAPY SERVICES			
Cardiac Rehabilitation Therapy	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Chemotherapy	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Manipulation Therapy	$40 *copayment* per visit	20% *coinsurance* after *deductible*	20 visits per benefit period
Occupational Therapy (includes Rehabilitative/Habilitative)	$40 *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 COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Physical Therapy (includes Rehabilitative/Habilitative)	$40 *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	$40 *copayment* per visit	20% *coinsurance* after *deductible*	
Speech Therapy (includes Rehabilitative/Habilitative)	$40 *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, services, devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Diagnostic Hearing Services	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Foot Care	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Refer to Foot Care benefit description.
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 COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Vision Care for Illness or Accidental Injury	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

COST-SHARING DESCRIPTIONS

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

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

Application of Cost Sharing

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

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

- Copayments
- Deductibles
- Coinsurance

In addition, you are responsible for any:

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

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

Copayment

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

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

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 (for example, laboratory tests). Also, some services result in separate charges for both the service and the use of the facility. This may result in more than one *copayment* being assessed for the covered service being provided to you.

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 we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on the *member's coverage*, there may be a *deductible* amount applicable only to *benefits* received for services provided by *in-network providers* and a separate *deductible* amount applicable only to *benefits* received for services provided by *out-of-network providers*.

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*, we 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 *in-network* and *out-of-network providers*.

*R*efer to the **Summary of Cost Sharing and Benefits** section to determine if any *deductibles* apply to your *coverage*.

Coinsurance

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

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

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

Out-of-Pocket Maximum

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

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

Benefit Period Maximum

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

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

Benefit Lifetime Maximum

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

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

Balance Billing Charges

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

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

- For *in-network providers*, the *allowable amount* for a *benefit* is set by the *provider's* contract with us. These contracts also include language whereby the *provider* agrees to accept the amount paid by us, minus any *cost-sharing amount* due from you, as payment in full.
- For *out-of-network providers*, the *allowable amount* for a *benefit* determines the maximum amount we will pay you for *benefits*. Since the *out-of-network provider* does not have a contract with us, the *provider* has not agreed to accept *the allowed amount* as payment in full. The *allowable amount* in these situations can be less than the *provider's* charge. Therefore, you are 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 us, or required by law, we will pay you for services performed by an *out-of-network provider.* You are responsible for paying the provider.

BENEFITS DESCRIPTIONS

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

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

Certain healthcare services require *preauthorization* by us or our designee. Please see the **Preauthorization Program** attachment to this *Benefits Booklet* for the list of services that require *preauthorization*.

Acute Care Hospital Room and Board and Associated Charges

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

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

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

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

Long-Term Acute Care Hospital

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

Acute Inpatient Rehabilitation

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

Allergy Services

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

Testing

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

Immunotherapy

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

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

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

Allergy Serums

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

Autism Spectrum Disorders

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 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 us*,* or the *contract holder's* Managed Behavioral Healthcare Organization*.* Review of the treatment plan will be required by us before authorization of services. Treatment plans will be reviewed every six 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 the following services (visit limits may apply when rendered to *members* aged 21 and older; refer to the **Summary of Cost-Sharing and Benefits** section 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, and 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 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 Services, Supplies and Education

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

Equipment, agents, and orthotics include the following:

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

Diabetes Education

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

Diagnostic Services

Diagnostic services are procedures ordered by a *physician* because of specific symptoms to determine a definitive condition or disease, not for screening purposes. *Benefits* for diagnostic services include, but are not limited to: radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening.

Laboratory Tests

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

In certain situations, an additional *cost-sharing amount* may be associated with a lab service performed by a *provider* that is not an independent laboratory. An independent laboratory is one that performs clinical pathology procedures and is not affiliated or associated with a *hospital, physician or facility provider*. For a list of independent laboratories, as well as how to access them, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *member 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 Positron Emission Tomography (PET Scan), Computerized Axial Tomography (CAT Scan), Magnetic Resonance Angiography (MRA), and Single Photon Emission Computed Tomography (SPECT Scan).

Dialysis Treatment

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

Durable Medical Equipment (DME) and Supplies

Durable medical equipment consists of items that meet these criteria:

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

- Reusable.
- Can withstand repeated use.

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

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

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

DME may be rented or purchased based on:

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

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

Except in circumstances of risk of disability or death, there are generally no *benefits* for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items.

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

Emergency and Urgent Care Services

Emergency Services

An *emergency service* is any healthcare service provided to 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 any one of the following:

- 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.
- 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 you are admitted as an *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient* consultation *copayment*.

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

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

Urgent Care Services

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

Enteral Nutrition

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

Benefits for enteral nutrition products are covered at standard *cost-sharing amounts* if the enteral nutrition product provides 50% or more of total nutritional intake.

Regardless of the percentage of 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 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 *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 healthcare *provider*. The exam generally includes a pelvic examination, a Pap smear, a breast examination, a rectal examination and a review of the patient's past health, menstrual cycle and childbearing history. *Benefits* for screening gynecological exams are covered under the **Preventive Care Services** section and are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Screening Papanicolaou Smear

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

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

Home Healthcare Services

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

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

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

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

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

Home Healthcare Visits Related to Mastectomies

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

Home Healthcare Visits Related to Maternity

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

Hospice Care

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

Residential Hospice Care involves palliative care provided in a *hospice* facility for the express or implied purpose of providing end-of-life care for the terminally ill patient who is unable to remain in the home and requires facility placement to provide for routine activities of daily living (ADLs) as well as specialized *hospice* care on a 24-hour-per-day basis.

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

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

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

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

Immunizations and Injections (Nonpreventive)

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

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

Infertility Services

Infertility is 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.

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), zygote intra-fallopian transfer (ZIFT), and artificial insemination are not covered.

Infusion Therapy

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

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

Benefits for infusion therapy include the procurement and preparation of the pharmaceuticals, biologicals and fluids; accompanying medications and solutions; supplies and equipment used to administer the infusions; and inpatient and outpatient care required to administer and monitor the infusions.

Interruption of Pregnancy

Benefits for an interruption of pregnancy include procedures for termination of a pregnancy performed through a medical or surgical procedure, including the administration of medication in a *provider's* office. Termination of the pregnancy must be nonelective.

Mammograms

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

Screening Mammogram

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

Diagnostic Mammogram

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

Maternity Services

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

Prenatal Services

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

Delivery

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

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

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

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

Postpartum Services

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

Medical Transport

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

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pickup is not accessible by land, and the transport is to an acute care hospital (whether for initial transport or subsequent transfer to another facility for special care).

Emergency Ambulance

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

Nonemergency Ambulance

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

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

Mental Healthcare Services

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

Inpatient Services

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

Partial Hospitalization

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

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

Outpatient Services

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

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

Newborn Care

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

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

Nutrition Therapy (Counseling and Education)

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

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

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

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

Office Visits, Consultations, Telehealth and Virtual Care

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

- *Telehealth* (audio and video)
- Provider office
- Hospital
- Retail facility

Visits

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

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.

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

Consultations

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

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

Coverage for consultations does not include the following:

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

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

Retail Clinic Services

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

Telehealth

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

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

Telehealth coverage does not include the following:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results
- Nurse call centers/advice centers
- Services involving remote invasive treatment and/or diagnostic testing
- Group counseling

Capital BlueCross Virtual Care

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

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

Capital BlueCross Virtual Care benefits are limited to the following *medically necessary* services:

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

Capital BlueCross Virtual Care coverage does not include:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results.
- Nurse call centers/advice centers.
- Services involving remote invasive treatment and/or diagnostic testing.
- Group counseling.

For information on accessing Capital BlueCross Virtual Care, visit CapitalBlueCross.com.

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

Pediatric

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

Adult

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

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** attachment due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. We follow guidelines set by the CDC 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*.

Prosthetic Appliances

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

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

Wigs are covered prosthetics in certain cases and may be subject to a *benefit lifetime maximum*. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered. Glasses, cataract lenses, contact lenses, and scleral shells prescribed after cataract or intra-ocular *surgery* **without** a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

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

Skilled Nursing Facility

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

Substance Use Disorder Services

Detoxification – Inpatient

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

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

Rehabilitation

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

Inpatient — *Benefits* for *inpatient substance use disorder* rehabilitation include: bed, board and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to you as an *inpatient* for *substance use disorder* 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)*, *partial hospitalization* or through *medication assisted treatment (MAT)*.

Surgery

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

Surgical Procedure

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

Outpatient Surgery

Outpatient surgery may be performed in an acute care *hospital* or *ambulatory surgical facility*. *Benefits* for *ambulatory surgical facilities* include those *outpatient surgeries* that, in the judgment of the provider,

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

Anesthesia Related to Surgery

Benefits for the administration of anesthesia related to *surgery* include services ordered by the attending *professional provider* and rendered by a *professional provider*, including the operating *physicians* under certain circumstances, but other than the assistant at *surgery*, or the attending *physician*.

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

Mastectomy and Related Services

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

Oral and Orthognathic Surgery

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

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

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

Other Surgeries

Benefits for other specialized surgical procedures include the following services:

- Routine neonatal circumcisions.

- Sterilization procedures.

Therapy Services

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

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

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

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 FDA guidelines.

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

Manipulation Therapy

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

Benefits include maintenance manipulation therapy for chronic pain management.

Occupational Therapy

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

Benefits for occupational therapy include rehabilitative and habilitative services.

Physical Therapy

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

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

Benefits for physical therapy include rehabilitative and habilitative services.

Radiation Therapy

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

Respiratory/Pulmonary Rehabilitation Therapy

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

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

Maintenance respiratory and pulmonary therapy is not covered.

Speech Therapy

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

Benefits for speech therapy include rehabilitative and habilitative services.

Transplant Services

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

Pre-Transplant Evaluation

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

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

Acquisition and Transplantation

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

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

- If we cover only the transplant recipient, we provide *benefits* for the recipient and for the donor, but only to the extent that donor benefits are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's coverage.

If we cover the transplant recipient and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

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

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

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

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

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

Post-Transplant Services

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

Blue Distinction Centers for Transplant (BDCT)

Blue Distinction Centers for Transplant are a cooperative effort of the BlueCross and/or BlueShield 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 you and one support companion. Items that are not covered include, but are not limited to, alcohol, tobacco, car rental, entertainment, expenses for persons other than you and your 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 Services

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

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

Foot Care

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

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

Orthodontic Treatment of Congenital Cleft Palates

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

Routine Costs Associated with Approved Clinical Trials

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

Vision Care for Illness or Accidental Injury

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

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

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

EXCLUSIONS

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

Anesthesia	• Anesthesia when administered by the assistant to the operating *physician* or the attending *physician*
Blood and Administration	• Prophylactic blood, cord blood or bone marrow storage to be used in the event of an accident or unforeseen *surgery* or transplant
Clinical Trials	• Services or supplies that we consider to be *investigational*, except routine costs associated with a*pproved clinical trials* Routine costs for clinical trials do not include any of the following and are therefore excluded from *coverage*: • The investigational drug, biological product, device, medical treatment, or procedure itself • The services and supplies provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient • The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial • Your travel expenses
Convenience	• Personal hygiene, comfort, 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) • Radios and televisions • Beauty or barber shop services • Incontinence supplies, deodorants • Guest trays, chairlifts, elevators, or any other modification to real or personal property, whether or not recommended by a *provider* • Spa or health club memberships • Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments such as premiums, which entitle those enrolled to services; repairs; or replacement of devices, equipment, or parts without charge or at a reduced charge
Cosmetic Surgery	• Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the

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

	adhesive removers, face masks, replacement batteries or alcohol pads • Supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices
Education	• Services provided at unapproved sites, for a *member's* individualized education program (IEP), or as part of a *member's* education, except as may be required by statue or explicit legal requirement
Eligibility	• Services incurred prior to your *effective date of coverage* • Services incurred after your *coverage* termination date except as provided for in this *Benefits Booklet*
Eligible Provider	• Services not billed and either performed by, or under the supervision of, an eligible *provider* • Services rendered by a *provider* who is a member of your *immediate family* • Telephone and electronic consultations, including *virtual services*, between you and a *provider*, except as otherwise provided in this *Benefits Booklet* • 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*
Experimental or Investigational	• Services or supplies we consider to be *investigational,* except where otherwise required by law
Food/ Nutritional Support	• Enteral nutrition due to lactose intolerance or other milk allergies • Blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Benefits Booklet* • All other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Benefits Booklet*
Foot Care	• Routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except *surgery* for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints;
Genetic Testing	• At-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic

	testing performed primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*
Hearing Aids	• Hearing aids, examinations for the prescription or fitting of hearing aids, and all related services
Immunizations	• Immunizations required for travel or employment except as required by law
Infertility Services	• Donor services related to assisted fertilization • Procedures to reverse sterilization • Any treatment or procedure leading to or in connection with assisted fertilization, such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and artificial insemination except as provided in this *Benefits Booklet* • For *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
Interruption of Pregnancy/Abortion	• For elective terminations of pregnancy
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by our Medical Director(s) or his/her designee(s)
Medicare	• Items or services paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws for any *member* who is enrolled in *Medicare*. This exclusion does not apply to the extent the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare*.
Medications	• All prescription and *over-the-counter* drugs dispensed by a pharmacy or *provider* for your *outpatient* use, whether or not billed by a *facility provider*, except for allergy serums, mandated pharmacological agents used for controlling blood sugar, FDA-approved drugs for the treatment of substance use disorder, and where otherwise required by law • All prescription and *over-the-counter* drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan that we approved
Military Services	• Services received by veterans and active military personnel at facilities operated by the U.S. Department of Veterans Affairs or

	by the Department of Defense, unless payment is required by law
Miscellaneous	• Care of conditions that federal, state, or local law requires to be treated in a public facility • Any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • Services you receive from a dental or medical department maintained by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar person or group • Charges for: failure to keep a scheduled appointment with a *provider*, completion of a claim or insurance form, obtaining copies of medical records, your decision to cancel a *surgery*, or hospital-mandated on-call service • Charges that exceed the *allowable amount*, except as otherwise provided for in this *Benefits Booklet* • *Cost-sharing amounts* you must pay as outlined in this *Benefits Booklet* • Autopsies or any other services rendered after a *member's* death • Any services related to or rendered in connection with a noncovered service, including but not limited to anesthesia and diagnostic services • Any other service or treatment, except as provided in this *Benefits Booklet*
Motor Vehicle Accident	• Cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy
Oral Surgery	• Oral *surgery* except as specifically provided in this *Benefits Booklet*
Prosthetics	• Prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device • Wigs and other items intended to replace hair loss due to male or female pattern baldness
Physical Exams	• Routine examination, counseling services, testing, screening, immunization, treatment or preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to: pre-marital examinations; employment or occupational screenings; or physicals for college, camp, sports, or travel
	•

Sexual Dysfunction	• Treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury
Sports Medicine	• Sports medicine treatment or equipment intended primarily to enhance athletic performance
Surgery	• All types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present
Therapy Services	• For acupuncture • Biofeedback therapy • Cognitive rehabilitation therapy, except when provided as 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) • Maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law • Occupational therapy or physical therapy for work hardening, vocational and prevocational assessment and training, and functional capacity evaluations, as well as this therapy's use towards enhancement of athletic skills or activities • All rehabilitative therapy, other than as described in the *Benefits Booklet*, including but not limited to play, music, hippotherapy, and recreational therapy
Temporomandibular Joint Syndrome	• 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 or treatment of TMJ caused by physical trauma resulting from an accident • Intra-oral reversible prosthetic devices or appliances regardless of the cause of TMJ
Transplant	• Services related to organ donation where you serve as an organ donor to a nonmember • Transplant services where human organs were sold rather than donated and for devices functioning as total artificial organs that are not approved by the FDA
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this *Benefits Booklet*
Vision Care	• Routine eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including

	but not limited to refractive lenses prescribed for use with an intra-ocular lens transplant • Routine vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses. • Surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy, and refractive keratoplasty
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared
Weight Loss	• *Inpatient* stays to bring about nonsurgical weight reduction
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy or coverage, or the applicable law.

MEDICAL CLINICAL MANAGEMENT PROGRAMS

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

Clinical Management programs include:

- Utilization Management
- Population Health Management
- Quality Improvement

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

Utilization Management

The Utilization Management program is a primary resource to identify *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

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

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

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

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

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

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

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

Investigational Treatment Review

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

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

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

Preauthorization

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

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

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

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

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

A *preauthorization* decision is generally issued within 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 our experienced registered nurses and board-certified physicians who evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in *inpatient* settings (acute care hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals). In addition, the program is designed to facilitate identification and referral of *members* to other Clinical Management Programs, such as Population Health 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 day of receiving all necessary information.

Discharge Planning – Discharge planning is performed by concurrent review nurses who communicate with hospital staff 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

Our 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 we receive a claim for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred any of the following ways:

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

We issue retrospective review decisions generally within **30** calendar days of receiving all necessary information.

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

Population Health Management

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

Care Management

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

Programs include, but are not limited to the following:

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

Complex Case Management

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

- With complex medical needs.
- At risk for future adverse health events.

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

Chronic Condition/Disease Management

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

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

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

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

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

Maternity Management

We offer a comprehensive Maternity Management program that provides education, care coordination, materials and support to pregnant women.

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

Using a custom predictive modeling tool, pregnant members are stratified into high and low-risk categories, as follows:

- **Individuals stratified as high risk** receive direct telephone outreach from a nurse experienced in all phases of pregnancy and deliver, including high-risk labor and delivery, newborn care and post-partum care.
- **Individuals stratified as low risk** receive an automated outbound call that offers health education information during each trimester of their pregnancy, as well as a follow up post-partum call. Members may request to be warm transferred to our clinical staff or request a call back from a clinician at any time.

Oncology Case Management

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

Transitions of Care

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

Transplant Case Management

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

Health Education and Wellness

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

Quality Improvement Program

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

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

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

How We Evaluate New Technology

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

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, *specialists* and professionals with expertise in the technology, and government agencies such as the

FDA, the National Institutes of Health, and the CDC. The five key criteria used by the Committee to evaluate new technology are:

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

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

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

Alternative Treatment Plans

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

If the *contract holder* elects to provide alternative *benefits* 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

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

Termination of Group Contract

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

Termination of Coverage for Members

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

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

- *Subscriber* – *Coverage* ends on the date a *subscriber* is no longer employed by, or 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 the *dependent* spouse ceases to be eligible under this *coverage*.
- Child – *Coverage* of a child ends on the date the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child – *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* disabled child.

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

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

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

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

CONTINUATION OF COVERAGE AFTER TERMINATION

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

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

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA* 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 the following:

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

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

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

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

Coverage for Medicare-Eligible Members

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

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

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

Coverage for Totally Disabled Members

Benefits will be furnished to a totally disabled *subscriber* or a totally disabled *dependent* for services **directly related** to the condition that caused this total disability and for no other condition, illness, disease, or injury if the *subscriber* or the *dependent* is totally disabled on the date *coverage* is terminated.

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

- The individual is unable to perform the substantial and material duties of his/her regular occupation and is not in fact engaged in any occupation for wage or profit.
- If the individual does not usually engage in any occupation for wage or profit, the *member* is substantially unable to engage in the normal activities of an individual of the same age and sex.

If an eligible *member* meets the definition of totally disabled, extended disability *benefits* are provided, based on whichever occurs first:

- Up to a maximum period of 12 consecutive months.
- Until the maximum amount of benefits has been paid.
- Until the total disability ends.
- Until the *member* becomes covered, without limitation as to the disabling condition, under any other coverage.

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

APPLYING FOR COVERAGE FOR TOTALLY DISABLED *MEMBERS* IS THE *MEMBER'S* RESPONSIBILITY.

CLAIMS REIMBURSEMENT FOR MEDICAL BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for healthcare services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which *we* receive a claim for *benefits* is dependent upon the type of *provider* from which you receive services. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

In-Network Providers

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

Out-of-Network Providers

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

Out-of-Area Providers

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

Allowable Amount

For *professional providers* and *facility providers*, we base the *benefit* payment amount 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 your *cost-sharing amount* obligations.

Filing a Claim

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

Obtain a copy of this claim form at CapitalBlueCross.com or by calling Member Services at the number found on the back of your *member ID card*. Your claim will process more quickly when this form is

used. A separate claim form must be completed for each person enrolled for *coverage* who received medical services.

A Special Note about Medical Records

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

Where to Submit Medical Claims

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

Capital BlueCross
PO Box 211457
Eagan, MN 55121

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

Out-of-Country Claims

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

Inpatient Hospital Claims

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

Professional Provider Claims

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

International Claim Form

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

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

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

Time Frames Applicable to Medical Claims

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

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

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

Special Time Frames Applicable to "Urgent Care" Claims

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

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

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

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

Special Time Frames Applicable to "Concurrent Care" Claims

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

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

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

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

Coordination of Benefits (COB)

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

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

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

Definitions Unique to Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, *preauthorization*, and preferred provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

a. Nondependent or Dependent.

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

For information regarding coordination of benefits with *Medicare*, please refer to the **Coordination of Benefits with Medicare** section.

b. Child Covered Under More Than One Plan.

Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of benefits is determined as follows:

(i) For a child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
- If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

(ii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the child's healthcare expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the child's healthcare expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or

- If there is no court decree allocating responsibility for the child's healthcare expenses or coverage, the order of benefits for the child is as follows:

  ◊ The Plan covering the Custodial Parent;

  ◊ The Plan covering the spouse of the Custodial Parent;

  ◊ The Plan covering the noncustodial parent; and then

  ◊ The Plan covering the spouse of the noncustodial parent.

(iii) For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non Dependent or Dependent "rule can determine the order of benefits.

d. *COBRA* or State Continuation Coverage.

If a *member* whose coverage is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non Dependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other healthcare coverage. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

If you are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non panel *provider*, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under This Coverage and other Plans. We may obtain and use the facts we need to apply these rules and determine benefits payable under This Coverage and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by us may result in claims being denied.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Coverage. If it does, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. We will not pay that amount again. The term “payment made” includes providing *benefits* in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

If a *subscriber* (or subscriber’s spouse), age 65 or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, then *Medicare* shall be

primary for the *subscriber* or spouse. The *benefits* of the *group contract* will then be the secondary form of coverage.

If a *subscriber* (or subscriber's spouse), age 65 or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, the following rules apply:

- The *group contract* will be primary for any person age 65 or older who is an Active Employee (defined as a person with "current employment status" under applicable *Medicare* Secondary Payer Laws) or the spouse of an Active Employee of any age.
- A *member* may decline *coverage* under the *group contract* and elect *Medicare* as the primary form of coverage. If the *member* elects *Medicare* as the primary form of coverage, the *group contract*, by law, cannot pay *benefits* secondary to *Medicare* for *Medicare*-covered *members*. However, the *member* will continue to be covered by the *group contract* as primary unless: (a) the *member*, or the *contract holder* on behalf of the *member*, notifies us, in writing, that the *member* does not want *benefits* under the *group contract*; or (b) the *member* otherwise ceases to be eligible for *coverage* under the *group contract*.

Disability

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with fewer than 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability, then *Medicare* shall be primary for the *member*; and the *group contract* will be the secondary form of *coverage*.

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with at least 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability — (other than End Stage Renal Disease as discussed below) the *group contract* will be primary for the *member*, and *Medicare* will be the secondary form of coverage.

End Stage Renal Disease (ESRD)

The *group contract* will remain primary for the first 30 months of a *member's* eligibility or entitlement to *Medicare* due to ESRD, 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.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to *providers* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made in Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the *benefits* under coverage.

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract.*
- Resulting from the application of any utilization review.
- Not provided because it is determined to be *investigational* or not *medically necessary*.

If you disagree with an adverse benefit determination with respect to *benefits* available under this *coverage* 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 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 you disagree with *an* adverse benefit determination, you may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, you may appoint a representative to act on your behalf as more fully discussed below. The appeal should include the reason(s) you disagree with the adverse benefit determination. The appeal must be received by us within 180 days after you received notice of the adverse benefit determination. Your appeal must be sent to:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

You may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, we will provide you with a full and fair internal review. We will provide you, free of charge, (1) with any new or additional evidence considered or relied upon, or generated in connection with the claim as well as (2) any new or additional rationale which may be the basis of a final internal adverse appeal determination as soon as possible and prior to issuing a decision on the appeal in order for you to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, we will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination. You may contact us at **800.962.2242** (TTY: **711**) to receive information on the internal review process and to receive

additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al* ***800.962.2242****.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

External Appeal Process

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on the our requirements for *medical necessity*, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission).

In order to request an external appeal pertaining to *medical necessity*, you must write to us at the address set forth above within four months from receipt of the Final Internal Adverse Benefit Determination. We will forward the appeal along with all materials and documentation to an IRO. You will be able to submit additional information to the IRO for consideration in the external appeal.

The IRO must notify you of its decision on the appeal in writing within 45 days from receipt of the request for external review.

*Member*s of a group health plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) may have a right to bring a civil action under Section 502(a) of ERISA.

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit determinations involving "urgent care decisions".

Expedited Internal Appeal Process for Claims Involving Urgent Care. You may seek expedited internal review of the determination of a claim involving urgent care by contacting us at the telephone number above. We will respond with a determination within 72 hours. You may also request an expedited external appeal simultaneously with the request for an expedited internal appeal. If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

Expedited External Appeal Process for Claims Involving Urgent Care. You may request an expedited external review of the Final Internal Adverse Benefit Determination involving an urgent care claim as defined above or where the decision concerns an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility. To request an expedited external appeal review of such a Final Internal Adverse Benefit Determination, you or your physician must contact us at the telephone number above and may provide a physician's certification indicating your claim is urgent in accordance with the definition above. Upon receipt of a request for an expedited external review, we will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a determination within 72 hours of receipt of the request.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit

Determination involving an urgent care claim as defined above and a concurrent care situation as defined below.

How to Appeal a Concurrent Care Claim Determination

Special rules apply to adverse benefit determinations involving "concurrent care decisions".

If we approved an ongoing course of treatment to be provided over a period of time or number of treatments, you have the right to an expedited appeal of any reduction or termination of that course of treatment by us before the end of such previously approved period of time or number of treatments. We will notify you of our decision to reduce or terminate your course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain an appeal decision before your *benefits* are reduced or terminated.

If you wish to appeal you must call Member Services at **800.962.2242** (TTY: **711**). We will notify you of the outcome of the appeal via telephone or facsimile not later than 72 hours after we receive the appeal. We will defer any reduction or termination of your ongoing course of treatment until a decision is reached on the appeal.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit Determination involving an urgent care claim as defined above and a concurrent care situation.

Designating an Individual to Act on Your Behalf

You may designate another individual to act on your behalf in pursuing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as your "authorized representative" or "designee" you must complete, sign, date, and return *Capital's* Member Authorization Form. You may request this form from our Member Services department at **800.962.2242** (TTY: **711**).

We communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

For purposes of reviewing *member* appeals, if *benefits* are provided under:

- An insured arrangement, we are the named fiduciary.
- A self-funded or "self-insured" arrangement, either the *plan sponsor* of the self-funded group health plan or we may serve as the named fiduciary.

The named fiduciary, with respect to any specific appeal, has full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any *member* is entitled to receive *benefits* under the terms of the group health plan. Any construction of terms of any plan document and any determination of fact adopted by the named fiduciary will be final and legally binding on all parties, subject to review only if such construction or determination is arbitrary, or capricious, or otherwise an abuse of discretion.

GENERAL PROVISIONS

Additional Services

From time to time, we, in conjunction with contracted companies, may offer other programs under this *coverage* to assist *members* in obtaining appropriate care and services.

Discounts and Incentives

We may also make available to our *members* access to health and wellness related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

These discount and incentive programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by us separately or independently from the *group contract*. There is no additional charge to *members* for accessing these discount and incentive programs. Contact the Plan Administrator for information on these programs.

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *Capital coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between *Capital* and *contract holder* without the consent or concurrence of the *members*. By electing *Capital* or accepting *Capital benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees with regard to *coverages* under this *contract*. Changes in *coverage* for *benefits* or changes in taxes or fees may result in upward adjustments in cost of *coverage* to reflect such changes. Such adjustments may occur on the earlier of either the *group contract* renewal date or the date such changes are required by law.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.*

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in medical policy, *preauthorization* requirements, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

In the future, should terms and conditions associated with this coverage change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Conformity with Statutes

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or nonuse of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular healthcare *provider*. If the *member's in-network provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Preferred Provider Organization ("PPO") program that is administered by *Capital* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. If there is a conflict of terms between the *policy/contract* and the *Benefits Booklet*, the terms of the *policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

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 *Benefits Booklet*, shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Member ID Cards

Capital provides *member ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member ID card* must be presented when service is requested.

Member ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *member ID cards* must be returned to us within 31 days of the end of a *member's* coverage. *Member ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Proof of Loss

Claims for proof of loss must be submitted within 12 months after completion of the covered services to receive benefits from *Capital*. *Capital* will not be liable under this *group contract* unless proper and prompt notice is furnished to *Capital* that covered services have been rendered to a *member*. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the **Schedule of Cost Sharing** section. 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 and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to *Capital* within the time specified will not reduce any benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will *Capital* be required to accept the proof of loss more than 12 months after benefits are provided, except if the person lacks legal capacity.

Time of Payment of Claims

Claim payment for *benefits* payable under this agreement will be processed immediately upon receipt of proper proof of loss.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost-sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Payment Recoupment

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* that should not have been paid by *Capital.*

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain the physician-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Capital* and healthcare *providers* (including PCPs and other *physicians*) is an independent contractor relationship. Healthcare *providers* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital*, and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital 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 an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Public Health Emergency

In the event that *Capital* reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, *Capital* may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, *member* cost share, provisions related to the use of an *in-network provider*, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination and Autopsy

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

ADDITIONAL INFORMATION

You may submit a written request for any of the following written information:

- A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Capital*.
- The procedures adopted by *Capital* to protect the confidentiality of medical records and other *member* information.
- A description of the credentialing process for *in-network providers*.
- A list of the *in-network providers* affiliated with in-network *hospitals*.
- If *prescription drugs* are provided as a *benefit* under this *coverage,* whether a specifically identified drug is included or excluded from this *coverage*.
- A description of the process by which an *in-network provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Capital* drug *formulary* for *prescription drugs* or biologicals when the *formulary's* equivalent has been ineffective in the treatment of the *member's* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member's* case, if *prescription drugs* are provided as a *benefit* under the *member's coverage*.
- A description of the procedures followed by *Capital* to make decisions about the nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by *Capital* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network provider*.
- A 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

You may also fax your requests to **717.541.6915** or by accessing CapitalBlueCross.com, or an email can be sent to Member Services.

You may inform us of your dissatisfaction with the quality of care or service you may have received by writing to the address above or by faxing us at the number above. You can also call Member Services to register the dissatisfaction (please refer to the **How to Contact Us** section for contact information).

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 HEALTHCARE*		
For Routine History and Physical Examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer chemoprevention • Contraceptive methods/counseling[1] • Folic Acid (childbearing age)	• Hormone Replacement Therapy (HRT) – risk vs. benefits • Urinary Incontinence Assessment	At least annually
Men and Women		
• Aspirin prophylaxis (high risk) • Calcium/vitamin D intake • Drug use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity/Exercise • Seat Belt use • Statin Medication (high risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) test	Testing every 2 years for women age 19-64 at increased risk for Osteoporosis. Once every 2 years for women over age 65 and older.
BRCA screening/genetic counseling/testing	For women at risk, including those not previously diagnosed with BRCA-related cancer but who have a personal or family history of cancer.
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 healthcare provider. Suggested testing is every 1-3 years.
Domestic/Interpersonal/Partner Violence screening/counseling	At least annually for women age 19 and older; provide or refer services as determined by your healthcare provider.
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 use 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 healthcare 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 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 age 18-79. 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: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
Obesity/Overweight + Cardiovascular Risk Factor combination	Age 19 and older for high risk adults: 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**	
Haemophilus Influenza type b (Hib)	Age 19 and older Based on individual risk or healthcare provider recommendation: one or three doses
Hepatitis A (HepA)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Hepatitis B (HepB)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Human Papillomavirus (9vHPV)	Age 19-26: Two or three doses, depending on age at series initiation.
Influenza	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 healthcare provider recommendation, one or two doses.
Meningococcal (conjugate) (MenACWY)	Age 19 and older Based on individual risk or healthcare 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 healthcare provider recommendation: Two or three doses depending on indication, then booster every 2-3 years if risk remain
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose (high risk; 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) Age 65 and older. Based on individual risk or healthcare provider recommendation: One dose at least 5 years after PPSV23
Tetanus/diphtheria/pertussis (Td or Tdap)	Age 19 and older One dose of Tdap, then Td or Tdap 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 located on the Capital BlueCross web site at capbluecross.com.

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)
- Depression screening (prenatal/ postpartum)
- 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 screening
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Asymptomatic Urine Bacteria Screening
- Other preventive services may be available as determined by your healthcare provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and 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 HEALTHCARE

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years [annually].

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (thru 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (thru 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, use/education
  - 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 use screening/ counseling																				✔	✔
Anemia screening			✔	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	At least annually for adolescents of childbearing age, 11 years of age and older; provide or refer services as determined by your healthcare provider.																				
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 7 and 9																				
Hearing test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
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 or younger for at risk: at every well-child visit. Confirm HBP outside office by Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV screening/risk assessment	Annually beginning at 11 years																				
HIV test	Routine one-time testing between 15-18 years old. If indicated by high risk assessment testing may begin earlier Periodic repeat testing (at least annually) of all high risk children.																				
Lead screening test/risk assessment	Screening Test: 12 to 24 months (at risk)[2]; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid screening/risk assessment				✔		✔		✔		✔				✔	✔	✔	✔	✔	✔		
Lipid test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal depression screening	By 1 month, 2 month, 4 month and 6 months																				
Newborn bilirubin screening	✔																				
Newborn blood screen *(as mandated by the PA Department of Health)*	✔																				
Newborn critical congenital heart defect screening	✔																				
	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**
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
Haemophilus influenza type b (Hib)	2 months, 4 months, 6 months (4 dose), 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk, as indicated
Hepatitis A (HepA)	12–23 months (2 doses) (catch-up through age 18)
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Human papillomavirus HPV	11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for those 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 12)
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)	16–18 years for individuals not at high risk; 10–18 years for those 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) for those at high risk.
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)
Rotavirus (RV)	2 months, 4 months, 6 months (3 doses) 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] Refer to the most recent Formulary located 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 an in-network provider (including a BlueCard facility participating provider providing inpatient services), the in-network provider will be responsible for obtaining the preauthorization. If members use an out-of-network provider or a BlueCard participating provider providing non-inpatient services, the out-of-network 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 our Utilization Management Department toll-free at 1-800-730-7219 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. In-network providers and members have full access to our medical policies and may request preauthorization for experimental or investigational services/items if there are unique member circumstances.

We only pay for services and items that are considered medically necessary. Providers and members can reference our medical policies for questions regarding medical necessity. Final determination of coverage is subject to the member's benefits and eligibility on the date of service.

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.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* 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*.

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. Capital may from time to time remove preauthorization requirements for benefits under certain dollar thresholds. For a listing of services currently requiring *preauthorization*, including any threshold requirements members and providers may consult CapitalBlueCross.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 use disorder)	*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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	
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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com
Select Cardiac Services		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at CapitalBlueCross.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 *non participating 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*.

Applicable Group Numbers

PPO Plan 270

July, 2021

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Colonial Intermediate Unit #20	00521915

APPENDIX D – TRANSPORTATION

Colonial Intermediate Unit 20

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 D 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

00521915

PPO

GROUP PREFERRED PROVIDER BENEFITS BOOKLET

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 Member Services 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).

ગુજરાતીમા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

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WELCOME

Thank you for choosing healthcare *coverage* from the Capital BlueCross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of Coverage") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under your group health plan. It also defines terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this coverage. We have also included our contact information so you can reach us when you have questions or concerns.

There are five sections in the *Benefits Booklet* that we would like to call out to help you to better understand your *coverage.* You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Cost Sharing and Benefits**, provides a summary of your *benefits* and any *benefit* limitations under your plan.
3. **Medical Benefit Exclusions**, lists the services not covered under your plan.
4. **Claims Reimbursement**, offers important information on how to file a claim for *benefits*.
5. **Appeal Procedures,** details the appeal process so you know how to file an appeal, if needed.

This *Benefits Booklet* also includes the following important materials:

- **A Schedule of Preventive Care Services** – This table shows guidelines for preventive care benefits.
- **The Preauthorization Program** – This program outlines services we need to review to determine if the services are *medically necessary*.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the subscriber. We may also say "you" or "your" to mean the member, which is anyone covered under your plan ("**dependents**").
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to, under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your coverage, we encourage you to call Member Services. You will find their number on the back of your *member identification (ID) card.*

IMPORTANT NOTICES

There are a few important points that you need to know about your *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your healthcare expenses. You should read this *Benefits Booklet* carefully to determine which healthcare services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your healthcare, use *in-network providers*.
- Your *benefits* may be subject to *cost-sharing amounts* including *copayments*, *deductibles*, and *coinsurance*. Refer to the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet* for specifics.
- *Benefits* are subject to review for *medical necessity* and may be subject to clinical management or utilization management. These programs help us make sure you receive the quality of care you need at the best price. Refer to **Medical *Clinical Management Programs*** section for more details.
- When applicable, if you fail to follow *Capital's* clinical management requirements, we may reduce the level of payment for *benefits or deny coverage*, even if the *benefits* are *medically necessary*. Refer to the **Medical Clinical Management Programs** section for specific requirements applicable to your *coverage*.
- We base our *medical necessity* determinations on whether a healthcare service is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying coverage. And we don't provide them financial incentives to encourage you to use fewer covered services.
- We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet*, *Certificates of Coverage* or Certificates of Insurance we may have issued to you previously under your coverage with the Capital BlueCross family of companies.
- The Summary of Benefits and Coverage (SBC) required by *PPACA* will be provided to you by the *contract holder*. The SBC contains only a partial description of the *benefits*, limitations and exclusions under this *coverage*. It is not intended to be a complete list or complete description of available *benefits*. If the SBC and *Benefits Booklet* do not agree, the terms and conditions of this *coverage* shall be governed solely by the *group contract* issued to the *contract holder*.
- The *group contract* is nonparticipating in any divisible surplus of premium.
- *Capital* does not assume any financial risk or obligation with respect to *benefits* or claims for such *benefits*.
- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.

HOW TO CONTACT US

We are committed to providing excellent service to you. We offer you a variety of ways to connect with us to answer your questions, confirm your benefits and coverage, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your benefits, claims, and cost-share balances. You can locate doctors, hospitals, and treatment costs; submit a request for preauthorization; change personal information or request member ID cards.

Member Services

Member Services representatives can answer your questions, confirm your benefits and coverage, and help you find in-network providers. They can help with questions about preauthorization for medical services. Member Services can also help answer your questions about how to access providers who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	**800.962.2242 or TTY users, 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital BlueCross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a CapitalBlue Connect Health and Wellness Center	Go to **CapitalBlueStore.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **The Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025

DEFINITIONS

The terms below have the following meanings whenever italicized in your *Benefits Booklet* or the *group contract*:

Allowable Amount: The maximum charge or payment level that we reimburse for *benefits* provided to you under your *coverage*.

- For *in-network providers*, the allowable amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
- For *out-of-network providers*, the allowable amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Benefits Booklet*.

Ambulatory Surgical Facility: A *facility provider* licensed and approved by the state in which it provides covered healthcare services or as otherwise approved by us and which meets the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis.
- Provides treatment by or under the supervision of *physicians* when the patient is in the facility.
- Does not provide *inpatient* accommodations.
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a *physician.*

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 meets the following criteria:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health (NIH)
    2. Centers for Disease Control and Prevention (CDC)
    3. Agency for Healthcare Research and Quality (AHRQ)
    4. Centers for Medicare and Medicaid Services (CMS)
    5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
    6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants.
    7. The VA, the DOD, or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
        a) The Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the NIH, and

b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug that is exempt from having such an investigational new drug application.

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 Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply. The *benefit period* does not include any part of a year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect. **The benefit period for this *coverage* 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.

Benefits: Those *medically necessary* healthcare services, supplies, equipment and facilities charges covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to *subscribers* as part of the *group contract* entered into by the *contract holder* and us. It explains the terms of this *coverage*, including the *benefits* available to *members* and information on how this *coverage* is administered.

Birth Defect: Also known as congenital anomalies, congenital disorders or congenital 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 licensed *facility provider* primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

BlueCard Program: A program that allows you to access covered healthcare services from *Host Blue in-network providers* of a Blue Cross and/or Blue Shield Licensee (Blue Plan) located outside the *service area*. The Blue Plan servicing the geographic area where the covered healthcare 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 *Benefits Booklet*.

Certified Registered Nurse: A *certified registered nurse* anesthetist, *certified registered nurse* practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any non-certified registered professional nurses employed by a healthcare facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Coinsurance: The percentage of the *allowable amount* that you are responsible to pay under the group contract. *Coinsurance* percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the coverage offered under your group health plan.

Copayment (Copay): The fixed dollar amount that you must pay for certain *benefits*. You may be required to pay copayments directly to the *provider* at the time of service or purchase. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Cost-Sharing Amount: The amount of covered services that you must pay. We subtract this amount from the *allowable amount* when we make payment to the provider for *benefits*. Cost-sharing amounts include: *copayments*, *deductibles*, and *coinsurance*.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

Custodial Care: Care provided primarily for your maintenance or which is designed essentially to assist you in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel to be performed safely and effectively.

Deductible: The amount of the *allowable amount* that you and your dependents, if any, must meet each *benefit period* before *benefits* are covered under the *group contract*. Deductibles are described in the **Summary of Cost Sharing and Benefits** section.

Dependent: Any member of a *subscriber's* family who satisfies the applicable eligibility criteria, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date your *coverage* under the *group contract* begins as shown on our records.

Emergency Medical Services (EMS) Agency: An entity that engages in the business or service of providing emergency medical services to patients by operating any of the following:

- An ambulance.
- An advanced life support squad vehicle.
- A basic life support squad vehicle.
- A quick response service.
- A special operations EMS service including, but not limited to the following:
  - a tactical EMS service.
  - a wilderness EMS service.

- an urban search and rescue EMS service.

A vehicle or service that provides emergency medical services outside of a healthcare facility.

Emergency Services: Any healthcare services provided to a *member* after the 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 any of the following:

- Placing the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.

Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Facility Provider: Includes the following:

- Ambulance Service *Provider*
- *Ambulatory Surgical Facility*
- *Birthing Facility*
- Durable Medical Equipment Supplier
- Facility/Hospital-owned Laboratory
- Freestanding Outpatient Facility
- *Freestanding Dialysis Treatment Facility*
- *Home Health Care Agency*
- *Hospice*
- *Hospital*
- *Infusion Therapy Provider*
- *Long-Term Acute Care Hospital*
- Orthotics Supplier
- Prosthetics Supplier
- *Psychiatric Hospital*
- *Rehabilitation Hospital*
- *Residential Treatment Facility*
- *Skilled Nursing Facility*
- *Substance Use Disorder Treatment Facility*
- Urgent Care Center

Fee Schedule: The predetermined fee maximums that we will pay for services performed by *out-of-network providers*, which are provided as *benefits* under this *coverage*. The fee schedule may be amended from time to time and may be adjusted based upon factors, including but not limited to, geographic location and *provider* types.

Freestanding Dialysis Treatment Facility: A licensed *facility provider* primarily engaged in providing dialysis treatment, maintenance or training on an *outpatient* or home care basis.

Freestanding Outpatient Facility: A licensed *facility provider* primarily engaged in providing *outpatient* diagnostic and/or therapeutic services by or under the supervision of *physicians*.

Functional Impairment: A condition that describes a state in which an individual is physically limited in the performance of basic daily activities.

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group 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 *Benefits Booklet*, between the *contract holder* and us for the administration of *benefits*.

Group Effective Date: The date 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 us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for coverage.

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.

Home Health Care Agency: A licensed *facility provider* that provides skilled nursing and other services on an intermittent basis in the *member's* home; and is responsible for supervising the delivery of such services under a plan prescribed by the attending *physician*.

Hospice: A licensed *facility provider* primarily engaged in providing palliative care to terminally ill *members* and their families with such services being centrally coordinated through an interdisciplinary team directed by a *physician*.

Hospital: A *facility provider* that meets the following criteria:

- Is licensed by the state in which it is located.
- Provides 24 hour nursing services by *certified registered nurse*s on duty or call.
- Provides services under the supervision of a staff of one or more *physicians* to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions.
- Is certified by the Joint Commission on the Accreditation of Healthcare Organizations, an equivalent body, or as accepted by us.

Hospital does not include: residential or nonresidential treatment facilities; nursing homes; *skilled nursing facilities*; facilities that are primarily providing custodial, domiciliary or convalescent care; or *ambulatory surgical facilities*.

Host Blue: A local Blue Cross and/or Blue Shield Licensee serving a geographic area other than our service area that has contractual agreements with providers in that geographic area, which participate in the *BlueCard program*, regarding claim filing or payment for covered healthcare services rendered to our *members* who use services of such *providers* when traveling outside of our service area.

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.

Infusion Therapy Provider: An entity that meets the necessary licensing requirements and is legally authorized to provide home infusion/IV therapy services.

In-network Provider(s): A *professional provider*, *facility provider*, or any other eligible healthcare *provider* or practitioner that is approved by us and, where licensure is required, is licensed in the applicable state and provides covered services and has entered into a *provider* agreement with or is otherwise engaged by us to provide *benefits* to you and who satisfies our credentialing and privileging criteria. The status of a *provider* as an in-network *provider* may change from time to time. It is your responsibility to verify the current status of a *provider.*

Inpatient: When you are admitted as a patient and 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 a room and board charge is made. This term may also describe the services rendered to you while admitted.

Intensive Outpatient Treatment Program (IOP): An intensive part-time specialized outpatient program that provides *substance use disorder* treatment services and support programs for relapse prevention which is typically two hours per day, three days per week.

Investigational: For the purposes of the *group contract*, a drug, treatment, device, or procedure is investigational if any of the following apply:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and final approval has not been granted at the time of its use or proposed use, and for a period of up to six (6) months thereafter, unless otherwise provided in our applicable medical policies.
- It is the subject of a current investigational new drug or new device application on file with the FDA.
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings.
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives.
- It is not investigational in itself, but would not be *medically necessary* except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records.
- The protocol(s) pursuant to which the treatment or procedure is to be delivered.
- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure.
- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue.
- Regulations and other official actions and publications issued by the federal government.
- The opinion of a third-party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Licensed Practical Nurse (LPN): A nurse who has graduated from a formal practical or vocational nursing educations program and licensed by the appropriate state authority.

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 hospitalization (average 25 days) and who would require high-intensity services. LTACHs are a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, the Pennsylvania Department of Health licenses LTACHs as an acute care facility.

Medicaid: Hospital or medical insurance benefits financed by the United States government under Title XIX of the Social Security Act of 1965 and its related regulations, each as amended.

Medical Necessity (Medically Necessary): Means the following

- Services or supplies that a *physician* exercising prudent clinical judgment would provide to a *member* for the diagnosis and/or direct care and treatment of the *member's* medical condition, disease, illness, or injury that are necessary.
- In accordance with generally accepted standards of good medical practice.
- Clinically appropriate for the *member's* condition, disease, illness or injury.
- Not primarily for the convenience of the *member* and/or the *member's* family, *physician*, or other healthcare *provider*.
- Not costlier than alternative services or supplies at least as likely to produce equivalent results for the *member's* condition, disease, illness, or injury.

For the purpose of this definition, "generally accepted standards of good medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national *physician* specialty society recommendations and the views of *physicians* practicing in relevant clinical areas and any other clinically relevant factors. The fact that a *provider* may prescribe, recommend, order, or approve a service or supply does not make it *medically necessary* or a covered *benefit*.

Medicare: The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965 and its related regulations, each as amended.

Medication Assisted Treatment (MAT): The use of FDA approved medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under COBRA) enrolled for *coverage* and entitled to receive covered services under the *group contract* in accordance with its terms and conditions. For purposes of the appeal processes, the term includes parents of a minor member as well as designees or legal representatives who are entitled or authorized to act on behalf of the member. The term member is sometimes identified with the pronouns "you" and "your" in this *Benefits Booklet*.

Member Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract.*

Mental Illness/Disorder: A health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and/or impaired functioning.

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account not delivered through the *BlueCard Program.*

Out-of-Network Provider(s): A *provider* that is not under contract with us or a *provider* who is not a *BlueCard in-network provider*.

Out-of-Pocket Maximum: A specified dollar amount of *deductible*, *copaymen*t, and *coinsurance* expense incurred by you or your family for covered services in a *benefit period*. After you have paid this amount, you are no longer required to pay any portion of the *allowable amount* for *benefits* during the remainder of that *benefit period*. The amount of, and types of cost-sharing applied to, the out-of-pocket maximum is described in the **Summary of Cost-Sharing and Benefits** section.

Outpatient: A *member* who receives services or supplies while not an *inpatient*. This term may also describe the services rendered to such a *member*.

Partial Hospitalization: The provision of planned and regularly scheduled medical, nursing, counseling, or therapeutic services in a *hospital* or nonhospital facility licensed as a mental healthcare or *substance use disorder* treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in *outpatient* treatment but who does not require *inpatient* care. To qualify, the partial hospitalization services must be provided for a minimum of four hours, with a maximum of 12 hours per day without incurring a charge for an overnight stay.

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 us or our designee that results from a process used to determine your eligibility at the time of the request, *benefit* coverage and the *medical necessity* of the proposed medical services before delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this *Benefits Booklet*.

Professional Provider: Includes any of the following:

- 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 *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

Provider Incentive: An additional amount of compensation paid to a healthcare *provider* by a 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 licensed facility *provider* primarily engaged in providing diagnostic and therapeutic services for mental *healthcare*. Such services are provided by or under the supervision of an organized staff of *physicians*.

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 qualify surgery, in the absence of bodily *functional impairment*, as being *reconstructive surgery*.

Rehabilitation Hospital: A licensed facility *provider* primarily engaged in providing skilled rehabilitation services for injured or disabled individuals to restore function following an illness or accidental injury. Skilled rehabilitation services consist of the combined use of medical and vocational services to enable *members* disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of *physicians*.

Remote Patient Monitoring: A type of service in which mobile medical technology for remote monitoring uses a wireless transmission of biometric data from anywhere the patient may be, directly to the doctor or care team member for the purpose of identifying clinical interventional needs when vital readings exceed patient specific norms to close gaps in medical care for high-risk populations.

Residential Treatment Facility (RTF): A licensed nonhospital *facility provider* that provides 24-hour level of care and 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 registered nurse 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 we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

Routine Costs Associated with Approved Clinical Trials: Routine costs include all the following:

- Covered services under this *Benefits Booklet* that typically would be provided absent an *approved clinical trial*.
- Services and supplies required solely for the provision of the *investigational* drug, biological product, device, medical treatment or procedure.
- The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.

- The services and supplies required for the diagnosis or treatment of complications.

Service Area: The 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.

Skilled Nursing Facility: A licensed *provider* primarily engaged in providing daily *skilled nursing services* and related skilled services to *members* requiring 24-hour skilled nursing services but not requiring confinement in an acute care general *hospital*. Such care is provided by or under the supervision of *physicians*. A skilled nursing facility is not, other than incidentally, a place that provides either of the following:

- Minimal care, *custodial care*, ambulatory care, or part-time care services.
- Care or treatment of mental illness or substance use disorder.

Skilled Nursing Services: Services that must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

Specialized Care Unit: A designated unit within an acute care *hospital* that has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, including neonatal intensive care and cardiac intensive care that is not critical care.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Substance Use Disorder: *Substance use disorder* is the use of alcohol or other drugs at dosages that place a *member's* social, economic, psychological, and physical welfare in potential hazard, or endanger public health, safety, or welfare. *Benefits* for the treatment of *substance use* disorder includes detoxification and rehabilitation.

Substance Use Disorder Treatment Facility: A *provider* licensed and approved by the state in which it provides healthcare services, or as otherwise approved by us 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 healthcare services are received.

Surgery: The performance of operative procedures, consistent with medical standards of practice, which physically changes some body structure or organ and includes usual and related pre-operative and post-operative care.

Telehealth: *Medically necessary* services provided to you by a *provider* in which the method of care delivery involves interaction between you and the *provider* using 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.

HOW TO ACCESS BENEFITS

Member ID Card

Your *member ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your *member ID card* and any other ID cards for other coverage each time you seek medical services. *Providers* use this information from your *member ID card* to submit claims for processing and payment.

IMPORTANT INFORMATION ABOUT YOUR MEMBER ID CARD:

- ***Preauthorization***: This term alerts *providers* that this element of your *coverage* is present. Refer to the **Preauthorization Program** attachment to this *Benefits Booklet* for more information.
- **Suitcase Symbol**: This symbol shows *providers* that your *coverage* includes BlueCard® and Blue Cross Blue Shield Global® Core. With both programs, you have access to *BlueCard in-network providers* nationwide and worldwide.
- ***Copayments****:* Healthcare *providers* use this information to determine the *copayment* they may collect from you at the time a service is rendered.

On the back of your *member ID card*, you will find important additional information on the following:

- Member Services' telephone number
- *Preauthorization* instructions and telephone number.
- General instructions for filing claims.

Please call Member Services if any information on your *member ID card* is incorrect or if you have questions. Remember to destroy old ID cards and use only the most recent *member ID card*.

Obtaining Benefits for Healthcare Services

We classify providers (doctors, clinics, hospitals, and so on) as either "in network" or "out of network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The provider you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an in-network provider.

Stay current about your providers. To confirm your providers are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your member ID card.

NOTE: Some *benefits* are covered only when you obtain services from an *in-network provider*.

Services Provided by In-Network Providers

An *in-network provider* is a healthcare *facility provider* or a *professional provider* who is properly licensed, where required, and has a contract **with us** to provide *benefits* under this *coverage*. Because *in-network providers* agree to accept our payment for covered *benefits* along with any applicable *cost-sharing amounts* that you are obligated to pay under the terms of this *coverage* as payment in full, you can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

All *in-network providers* must seek payment for healthcare services, other than *cost-sharing amounts*, directly from us. ***In-network providers* may not seek payment from you for services that qualify as *benefits*.** However, an *in-network provider* may seek payment from you for noncovered services, including specifically excluded services (e.g. cosmetic procedures, etc.), or services in excess of *benefit lifetime maximums* and *benefit period maximums*. The *in-network provider* must inform you before performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability.

The status of a *provider* as an *in-network provider* may change from time to time. It is the *member's* responsibility to verify a *provider's* current network status. To find an *in-network provider*, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your member ID card.

Services Provided by Out-of-Network Providers

An *out-of-network provider* is a *provider* who does not contract with us or with another *Host Blue* to provide *benefits* to you.

Services provided by *out-of-network providers* may require you to pay higher *cost-sharing amounts* or may not be covered *benefits*. If services are covered, *benefits* will be reimbursed at a percentage of the *allowable amount* applicable to this *coverage* with us. Information on whether *benefits* are provided when performed by an *out-of-network provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Cost Sharing and Benefits** section.

Because *out-of-network providers* are not obligated to accept our payment as payment in full, you may be responsible for the difference between the *provider's* charge for that service and the amount we 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 we pay for the service and what the *provider* charged. In addition, unless otherwise required by law, all payments are made directly to the *subscriber*; and then you are responsible for reimbursing the *provider*. Additional information on balance billing charges can be found in the **Cost-Sharing Descriptions** section.

Emergency Services

An *emergency service* is any healthcare service provided to you 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 any of the following:

- Placing your health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.

Examples of conditions requiring *emergency services* are: excessive bleeding; broken bones; serious burns; sudden onset of severe chest pain; sudden onset of acute abdominal pains; poisoning; unconsciousness; convulsions; and choking. In these circumstances, 911 services are appropriate and do not require *preauthorization*.

Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* are *benefits* if the condition qualifies as an *emergency service*.

In a true emergency, the first concern is to obtain necessary medical treatment; so you should seek care from the nearest appropriate *facility provider*

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of our *service area*, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside our *service area*, you will receive it from one of two kinds of *providers.* Most providers ("*in-network providers*") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("*out-of-network providers*") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program

Under the *BlueCard Program*, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its in-network *providers*.

When you access covered healthcare services outside our *service area* and the claim is processed through the *BlueCard Program*, the amount you pay for covered healthcare services is calculated based on the lower of either of the following:

- The billed covered charges for your covered services.
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare *provider* or *provider* group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare *providers* after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

Out-of-Network Healthcare Providers Outside Capital's Service Area

***Member* Liability Calculation** – When covered healthcare services are provided outside of our *service area* by out-of-network *providers*, the amount you pay for such services will normally be based on either the Host Blue's out-of-network *provider* local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the out-of-network *provider* bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions – In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our *service area*, or a special negotiated payment, to determine the amount we will pay for services provided by out-of-network healthcare *providers*. In these situations, you may be liable for the difference between the amount that the out-of-network *provider* bills and the payment we will make for the covered services as set forth in this paragraph.

Special Cases: Value-Based Programs

BlueCard Program

If you receive covered healthcare services under a *Value-Based Program* inside a Host Blue's service area, you will not be responsible for paying any of the *provider incentives*, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs – *Negotiated (Non-BlueCard Program) Arrangements*

If we have entered into a *negotiated arrangement* with a Host Blue to provide Value-Based Programs to contract holder on your behalf, we will follow the same procedures for *Value-Based Programs* administration and care coordinator fees as noted above for the BlueCard Program.

Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. The Blue Cross Blue Shield Global Core is unlike the *BlueCard Program* available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at **800.810.BLUE** (2583) or call collect at **804.673.1177**, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the cost-sharing amounts (deductibles, coinsurance, etc.). In such cases, the hospital will submit the claims to the service center to begin claims processing.

However, if you pay in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. **You must contact us to obtain precertification for nonemergency inpatient services.**

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with a claim submission, call the service center at **800.810.BLUE** (2583) or call collect at **804.673.1177**, 24 hours a day, seven days a week.

SUMMARY OF COST SHARING AND BENEFITS

The following table provides a summary of the applicable *cost-sharing amounts* and *benefits* provided under this *coverage*.

The *benefits* listed in this section are covered when *medically necessary* and preauthorized (when required) in accordance with our *c*linical management policies and procedures.

It is important to remember that this *coverage* is subject to the exclusions, conditions, and limitations as described in this *Benefits Booklet*. Please see the **Cost-Sharing Descriptions**, **Benefit Descriptions**, and **Exclusions** sections for a specific description of the *benefits* and *benefit* limitations provided under this *coverage.*

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DEDUCTIBLE (PER BENEFIT PERIOD)			
Deductible (Per Benefit Period)	$625 per *member* $1,250 per family	$1,250 per *member* $2,500 per family	Copayments and coinsurance do not apply to deductible.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
OUT-OF-POCKET MAXIMUM			
Out-of-Pocket Maximum When you reach your out-of-pocket maximum, we pay all subsequent claims during the remainder of the benefit period at 100% of the allowable amount, except that coinsurance continues to apply for out-of-network facility providers.	$4,275 per member $8,550 per family The in-network out-of-pocket maximum includes all deductible, copayments, and coinsurance for benefits received from in-network providers.	$2,000 per member $4,000 per family The out-of-network out-of-pocket maximum includes only coinsurance for out-of-network professional providers.	The following expenses do not apply to either the in-network or out-of-network out-of-pocket maximum: • Expenses incurred for payment of a benefit after any applicable benefit period maximum has been exhausted The following expenses do not apply to the out-of-network out-of-pocket maximum: • Deductible • Copayments • Facility provider Coinsurance; and • Charges exceeding the allowable amount
ACUTE CARE HOSPITAL ROOM AND 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*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DIABETIC SERVICES, SUPPLIES AND EDUCATION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
DIAGNOSTIC SERVICES			
Laboratory Tests	Covered in full after *deductible* when performed at an independent laboratory or drawn at a physician's office and sent to an independent laboratory. Covered in full after *deductible* , when performed at a facility/hospital owned laboratory	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospital* Laboratory *Facility* 50% *coinsurance* after *deductible* at an *Freestanding Diagnostic Facility*	
All other Medical Tests	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Radiology Services (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*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.** **OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DIALYSIS TREATMENT			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* Not Covered for *Freestanding Dialysis Facility Provider*	
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Durable Medical Equipment Supplier *Facility*	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services	$100 *copayment* per visit, *copayment* waived if admitted **Note: Your cost share is the same regardless of whether an in-network provider or an out-of-network provider delivers the emergency services.** (Only one ER copayment will apply for the administration of the rabies vaccine series at the initial visit/injection.)		**Refer to Emergency and Urgent Care Services benefit description for more details** Limitation within 72 hours and all follow up
Urgent Care Services	$45 *copayment* per visit	20% *coinsurance* after *deductible*	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 Lmitation within 24 hours *

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
ENTERAL NUTRITION			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Enteral nutrition products for certain therapeutic treatments are not subject to deductible. See Benefit Descriptions section for details.
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 HEALTHCARE SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Home Health Care Agency Facility*	90 visits per *benefit period*
HOSPICE CARE			
Benefits (includes *Residential Hospice Care*)	Inpatient hospice Covered in full after *deductible* Outpatient hospice Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Hospice Facility*	
IMMUNIZATIONS AND INJECTIONS (NONPREVENTIVE)			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
INFERTILITY SERVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
INFUSION 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* for facility services Covered in full after *deductible* for professional services	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Birthing Facility*	
MEDICAL TRANSPORT			
Emergency Ambulance	Covered in full *deductible* waived **Note: Cost share is the same regardless of whether the emergency services are provided by an in-network *provider* or an *out-of-network provider*.**		
Nonemergency Ambulance	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
MENTAL HEALTHCARE SERVICES			
Inpatient Services	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital *Facility*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
Partial Hospitalization	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric *Partial Hospitalization Facility*	
Outpatient Services	$20 *copayment* per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Psychiatric Hospital *Facility*	
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*	20 visits for chronic management conditions per *benefit period* 2 visits per *benefit period* for nonpreventive obesity services
OFFICE VISITS, CONSULTATIONS, TELEHEALTH AND VIRTUAL CARE			
Inpatient Consultations	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Outpatient Office Visit, Consultations, Clinic, and Telehealth Visits	$20 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 copayment per visit for all other professional providers	20% coinsurance after deductible	Includes in-person and telehealth visits.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Virtual *Care Visits delivered via the Capital BlueCross Virtual Care platform*	$10 *copayment* per visit	Not Covered	Service provided by a contracted vendor and delivered via the Capital BlueCross Virtual Care platform
ORTHOTIC DEVICES			
Benefits	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Orthotic Supplier *Facility*	Foot orthotics are covered for all members for any reason
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care	Covered in full *deductible* waived	20% *coinsurance*, *deductible* waived for Pennsylvania mandated childhood immunizations	(includes physical examinations, childhood immunizations and tests)
Adult Preventive Care	Covered in full *deductible* waived	20% *coinsurance* after *deductible*	(includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law) Preventive PSA Test age limit is 45 and older for males. Preventive bone density test age limit 50 and older for females.
PRIVATE DUTY NURSING SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an Prosthetic Supplier Facility	
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* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
Rehabilitation – Inpatient	Covered in full after *deductible*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	
Rehabilitation – Outpatient	$20 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible* 50% *coinsurance* after *deductible* at an *Substance Use Disorder Treatment Facility*	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
SURGERY			
Outpatient Surgery Facility	Covered in full after *deductible*, for *outpatient* surgical procedures performed at an *Ambulatory Surgical Facility*. Covered in full after *deductible*, for *outpatient* surgical procedures performed at an Acute Care Hospital facility.	50% *coinsurance* after *deductible* covered at an *Ambulatory Surgical Facility*. 50% *coinsurance* after *deductible* at an *Hospital Facility*	
Professional Surgery Services including Anesthesia	Covered in full after *deductible*	20% *coinsurance* after *deductible*	(Includes Inpatient and Outpatient professional surgical services)
THERAPY SERVICES			
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)
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)

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE REFLECTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST.

OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE ADDITIONAL COSTS TO YOU OVER AND ABOVE ANY DEDUCTIBLE, COPAYMENTS AND COINSURANCE.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
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, services, devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Diagnostic Hearing Services	Covered in full after *deductible*	20% *coinsurance* after *deductible*	
Foot Care	Covered in full after *deductible*	20% *coinsurance* after *deductible*	Refer to Foot Care benefit description.
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*	
Vision Care for Illness or Accidental Injury	Covered in full after *deductible*	20% *coinsurance* after *deductible*	

COST-SHARING DESCRIPTIONS

This section of the *Benefits Booklet* describes the cost sharing that may be required under your *coverage* with *Capital*.

Because *cost-sharing amounts* vary depending on your specific *coverage*, it is important that you refer to the **Summary of Cost Sharing and Benefits** section. That section shows the services that are covered and the applicable cost-sharing amounts (***copayments, deductibles***, and ***coinsurance***) for each benefit.

Application of Cost Sharing

All payments made by us for *benefits* are based on the *allowable amount*. The *allowable amount* is the maximum amount that we will pay for *benefits* under this *coverage*. Before we make payment, any applicable *cost-sharing amount* is subtracted from the *allowable amount*.

Payment for healthcare *benefits* may be subject to any of the following cost sharing:

- Copayments
- Deductibles
- Coinsurance

In addition, you are responsible for any:

- Balance billing charges, which are amounts due to an *out-of-network provider* that exceed the *allowable amount*.
- Services for *benefits* not provided under your *coverage*, regardless of the *provider's* network status.

Under certain circumstances, if we pay the healthcare *provider* amounts that are your responsibility, such as *deductible*, *copayments* or *coinsurance*, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Copayment

A *copayment* is a fixed dollar amount that you must pay directly to the *provider* for certain *benefits* at the time of service. *Copayment* amounts may vary, depending on the type of healthcare service for which *benefits* are being provided and/or the type of *provider* performing the service.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *copayments* apply to your *coverage*.

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 (for example, laboratory tests). Also, some services result in separate charges for both the service and the use of the facility. This may result in more than one *copayment* being assessed for the covered service being provided to you.

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 we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on the *member's coverage*, there may be a *deductible* amount applicable only to *benefits* received for services provided by *in-network providers* and a separate *deductible* amount applicable only to *benefits* received for services provided by *out-of-network providers*.

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*, we 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 *in-network* and *out-of-network providers*.

*R*efer to the **Summary of Cost Sharing and Benefits** section to determine if any *deductibles* apply to your *coverage*.

Coinsurance

Coinsurance is the percentage of the *allowable amount* payable for a *benefit* that you are responsible to pay. Depending on your *coverage*, the *coinsurance* may be calculated as two separate percentages: one for *benefits* received for services provided by *in-network providers,* and one for *benefits* for services provided by *out-of-network providers*.

A claim for an *out-of-network provider* is calculated differently than a claim for an *in-network provider*.

*R*efer to the **Summary of Cost Sharing and Benefits** section to determine if *coinsurance* applies to your *coverage*.

Out-of-Pocket Maximum

The *out-of-pocket maximum* is the maximum *cost-sharing amount* that an individual *subscriber* or a *subscriber's* entire family must pay during a *benefit period*. Depending on the *subscriber's coverage*, there may be an *out-of-pocket maximum* amount applicable only to *benefits* received for services provided by *in-network providers* and a separate *out-of-pocket maximum* amount applicable only to *benefits* received for services provided by *out-of-network 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*, *we* 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 *in-network* and *out-of-network providers*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *out-of-pocket maximums* apply to your *coverage*.

Benefit Period Maximum

A *benefit period maximum* is the limit of coverage placed on a specific *benefit(s)* provided under this *coverage* within a *benefit period*. Such limits on *benefits* may be in the form of visits, days, or dollars; and there may be more than one limit on a specific *benefit*. This *coverage* has no dollar limits on Essential Health Benefits, as that term is defined by *PPACA*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit period maximums* apply to your *coverage*.

Benefit Lifetime Maximum

A benefit lifetime maximum is the maximum amount for a specific *benefit(s)* payable by us during the duration of your *coverage* under the *group contract* or other *group contracts* from the Capital BlueCross family of companies. This *coverage* has no *benefit lifetime maximums* on Essential Health Benefits, as that term is defined by *PPACA*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit lifetime maximums* apply to your *coverage*.

Balance Billing Charges

Providers have an amount that they bill for the services or supplies furnished to *members*. This amount is called the *provider's* billed charge. There may be a difference between the *provider's* billed charge and the *allowable amount*.

How the interaction between the *allowable amount* and the *provider's* billed charge affects the payment for *benefits* and the amount you will be responsible for paying a *provider* varies depending on whether the *provider* is an *in-network provider* or an *out-of-network provider*.

- For *in-network providers*, the *allowable amount* for a *benefit* is set by the *provider's* contract with us. These contracts also include language whereby the *provider* agrees to accept the amount paid by us, minus any *cost-sharing amount* due from you, as payment in full.
- For *out-of-network providers*, the *allowable amount* for a *benefit* determines the maximum amount we will pay you for *benefits*. Since the *out-of-network provider* does not have a contract with us, the *provider* has not agreed to accept *the allowed amount* as payment in full. The *allowable amount* in these situations can be less than the *provider's* charge. Therefore, you are 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 us, or required by law, we will pay you for services performed by an *out-of-network provider.* You are responsible for paying the provider.

BENEFITS DESCRIPTIONS

Subject to the terms, conditions, definitions, and exclusions specified in this *Benefits Booklet* and subject to the payment of the applicable *cost-sharing amounts*, if any, you shall be entitled to receive *coverage* for the *benefits* listed below. Services will be covered by us only if: a) they are medically necessary, and b) they are preauthorized (if required) by us and/or our designee, and c) you are actively enrolled at the time of the service.

It is important to refer to the Summary of Cost Sharing and Benefits section to determine whether a healthcare service described in this section is a covered *benefit.* Also reference the Summary of Cost-Sharing and Benefits section to determine the cost-sharing amounts you are responsible for paying to *providers* and whether any *benefit* limitations/maximums apply to this *coverage*.

Certain healthcare services require *preauthorization* by us or our designee. Please see the **Preauthorization Program** attachment to this *Benefits Booklet* for the list of services that require *preauthorization*.

Acute Care Hospital Room and Board and Associated Charges

Benefits for room and board in an acute care hospital include bed, board, and general nursing services when you occupy any of the following:

- A semi-private room (two or more beds).
- A bed in a *specialized care unit*.
- A private room, if *medically necessary* or if no semi-private accommodations are available. A private room is not *medically necessary* when used solely for your comfort or convenience.

Benefits for associated services include, but are not limited to, the following:

- Drugs and medicines provided for use while an *inpatient*
- Use of operating or treatment rooms and equipment
- Oxygen and administration of oxygen
- Medical and surgical dressings, casts and splints

Long-Term Acute Care Hospital

Benefits for *long-term acute care hospitals* include services provided when you are acutely ill and would otherwise require an extended stay in an acute care setting.

Acute Inpatient Rehabilitation

Benefits for acute *inpatient* rehabilitation provided in a *rehabilitation hospital* include services provided when you require an intensive level of skilled *inpatient* rehabilitation services on a daily basis and these skilled rehabilitation services are provided in accordance with a *physician's* order. We must agree with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

Allergy Services

Benefits for allergy services include testing, immunotherapy, and allergy serums.

Testing

Benefits for tests used in the diagnosis of allergy to a particular substance include direct skin testing (i.e., percutaneous, intracutaneous, intradermal) as well as in vitro techniques (i.e., RAST, MAST, FAST).

Immunotherapy

Immunotherapy refers to the treatment of disease by stimulating the body's own immune system and involves injections over a period of time in order to reduce the potential for allergic reactions.

Benefits for immunotherapy include therapy provided to individuals with a demonstrated hypersensitivity that cannot be managed by avoidance or environmental controls.

However, certain methods of treatment, which are *investigational*, as well as items that are for personal convenience (for example, pillows, mattress casing, air filters) are not covered.

Allergy Serums

Benefits for allergy serums include the immunizing agent (serum) used in immunotherapy injections as long as the immunotherapy itself is covered.

Autism Spectrum Disorders

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 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 us*,* or the *contract holder's* Managed Behavioral Healthcare Organization*.* Review of the treatment plan will be required by us before authorization of services. Treatment plans will be reviewed every six 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 the following services (visit limits may apply when rendered to *members* aged 21 and older; refer to the **Summary of Cost-Sharing and Benefits** section 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, and 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 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 Services, Supplies and Education

Unless otherwise covered under a prescription drug program, *benefits* for diabetic drugs and supplies include drugs, including insulin, equipment, agents, and orthotics used for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes when prescribed by a *provider* legally authorized to prescribe such items. Diabetic supplies do not include batteries, alcohol swabs, preps or gauze.

Equipment, agents, and orthotics include the following:

- Injectable aids (e.g., syringes)
- Pharmacological agents for controlling blood sugar
- Blood glucose monitors and related supplies
- Insulin infusion devices
- Orthotics (e.g., diabetic shoes and foot orthotics mandated by Pennsylvania state law are covered)

Diabetes Education

Benefits for diabetes self-management training and education include participation in a diabetes self-management training and education program approved by the American Diabetes Association or American Association of Diabetes Educators under the supervision of a licensed healthcare professional with expertise in diabetes, and subject to the criteria determined by us. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association or American Association of Diabetes Educators.

Diagnostic Services

Diagnostic services are procedures ordered by a *physician* because of specific symptoms to determine a definitive condition or disease, not for screening purposes. *Benefits* for diagnostic services include, but are not limited to: radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening.

Laboratory Tests

Benefits for laboratory tests include diagnostic pathology and laboratory tests for the diagnosis or treatment of a disease or condition.

In certain situations, an additional *cost-sharing amount* may be associated with a lab service performed by a *provider* that is not an independent laboratory. An independent laboratory is one that performs clinical pathology procedures and is not affiliated or associated with a *hospital, physician or facility provider*. For a list of independent laboratories, as well as how to access them, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *member 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 Positron Emission Tomography (PET Scan), Computerized Axial Tomography (CAT Scan), Magnetic Resonance Angiography (MRA), and Single Photon Emission Computed Tomography (SPECT Scan).

Dialysis Treatment

Benefits for dialysis include the *inpatient* or *outpatient* treatment of acute renal failure or chronic renal insufficiency for removal of waste materials from the body.

Durable Medical Equipment (DME) and Supplies

Durable medical equipment consists of items that meet these criteria:

- Primarily and customarily used to serve a medical purpose.
- Not useful to a person in the absence of illness or injury.
- Ordered by a *professional provider* within the scope of their license.
- Appropriate for use in the home.

- Reusable.
- Can withstand repeated use.

Examples of covered DME are wheelchairs, canes, walkers, and nebulizers when shown to be *medically necessary*.

Examples of noncovered DME include but are not limited to iPads, home computers, laptops, and wearable activity or health monitors. Enteral pumps are only a covered DME when the enteral nutrition is considered *medically necessary.*

Benefits for DME include reasonable repairs, adjustments and certain supplies that are necessary to use and maintain the DME in operating condition. Repair costs cannot exceed the purchase price of the DME. Routine periodic maintenance (e.g., testing, cleaning, regulating and checking of equipment) for which the owner or vendor is generally responsible is not covered.

DME may be rented or purchased based on:

- *Member's* condition at diagnosis
- *Member's* prognosis
- Anticipated time frame for use
- Total costs

Reimbursement on a rental DME cannot exceed the lesser of the established fee schedule price, billed amount, usual or customary purchase price of the equipment. When you purchase a DME, the previous allowances for its rental will be deducted from the amount allowed for its purchase.

Except in circumstances of risk of disability or death, there are generally no *benefits* for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items.

Medical supplies are medical goods that **support** the provision of therapeutic and diagnostic services but cannot withstand repeated use and are disposable or expendable in nature. *Benefits* for medical supplies include items such as hoses, tubes and mouthpieces that are *medically necessary* for proper functioning of covered DME.

Emergency and Urgent Care Services

Emergency Services

An *emergency service* is any healthcare service provided to 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 any one of the following:

- 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.
- 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 you are admitted as an *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient* consultation *copayment*.

Benefits for emergency dental accident services include only treatment required to stabilize you immediately following an accidental injury, which includes injuries caused by a mental condition or an act of domestic violence. Treatment of accidental injuries resulting from chewing or biting is not covered.

Upon reviewing the emergency room records, if we determine that the services provided do not qualify as *emergency services*, those nonemergency services may not be covered or may be reduced according to the limitations of this *coverage*.

Urgent Care Services

Benefits for services performed in an urgent care center include those that, in the judgment of the *provider*, are not life-threatening and urgent. These services can be treated on other than an inpatient hospital basis and are performed at a freestanding urgent care center by a duly licensed associated physician or allied health professional practicing within the scope of his/her licensure and specialty. *Urgent care services* are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours, and offer significant extended hours, which may include evenings, holidays and weekends.

Enteral Nutrition

Enteral nutrition involves the use of special formulas and medical foods that are administered by mouth or through a tube placed in the gastrointestinal tract. *Benefits* for enteral nutrition include enteral nutrition products (i.e. special formulas and medical food, as defined by the U.S. Food and Drug Administration), as well as *medically necessary* enteral feeding equipment (e.g. pumps, tubing, etc.).

Benefits for enteral nutrition products are covered at standard *cost-sharing amounts* if the enteral nutrition product provides 50% or more of total nutritional intake.

Regardless of the percentage of 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 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 *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 healthcare *provider*. The exam generally includes a pelvic examination, a Pap smear, a breast examination, a rectal examination and a review of the patient's past health, menstrual cycle and childbearing history. *Benefits* for screening gynecological exams are covered under the **Preventive Care Services** section and are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Screening Papanicolaou Smear

A Papanicolaou (Pap) smear is a laboratory study used to detect cancer. The Pap test has been used most often in the diagnosis and prevention of cervical cancers. *Benefits* for Pap smears are covered under the **Preventive Care Services** section and are highlighted on the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Diagnostic Pap smears are covered under the **Diagnostic Services, Laboratory Tests** section and may be subject to *cost-sharing amounts*.

Home Healthcare Services

Home healthcare is *medically necessary* skilled care provided to a homebound patient for the treatment of an acute illness, an acute exacerbation of a chronic illness, or to provide rehabilitative services.

Benefits for home healthcare services provided to a homebound patient can include all of the following:

- Professional services when provided by appropriately licensed and certified individuals.
- Physical therapy, occupational therapy, and speech therapy.
- Medical and surgical supplies provided by the home health care agency.
- Medical social service consultation.

No home healthcare *benefits* are provided for any of the following:

- Drugs provided by the *home health care agency* with the exception of intravenous drugs administered under a treatment plan we approved.
- Food or home delivered meals.
- Homemaker services such as shopping, cleaning and laundry.
- Maintenance therapy.
- Custodial care.

Home Healthcare Visits Related to Mastectomies

Benefits for home healthcare visits related to mastectomies include one home healthcare visit, as determined by your *physician*, received within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.

Home Healthcare Visits Related to Maternity

Benefits for home healthcare visits related to maternity include one home healthcare visit within 48 hours after discharge when the discharge occurs prior to 48 hours of *inpatient* care following a normal vaginal delivery or prior to 96 hours of *inpatient* care following a cesarean delivery. Home healthcare visits can include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed healthcare *provider* whose scope of practice includes postpartum care must make such home healthcare visits. At the mother's sole discretion, the home healthcare visit may occur at the facility of the *provider*. Home healthcare visits following an *inpatient* stay for maternity services are not subject to *copayments*, *deductibles*, or *coinsurance*, if applicable to this *coverage.*

Hospice Care

Hospice care involves palliative care to terminally ill *members* and their families with such services being centrally coordinated through a multi-disciplinary *hospice* team directed by a *physician*. Most *hospice* care is provided in the *member's* home or facility that the *member* has designated as home (i.e. assisted living facility, nursing home, etc.).

Residential Hospice Care involves palliative care provided in a *hospice* facility for the express or implied purpose of providing end-of-life care for the terminally ill patient who is unable to remain in the home and requires facility placement to provide for routine activities of daily living (ADLs) as well as specialized *hospice* care on a 24-hour-per-day basis.

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.
- *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 our criteria for residential hospice care.
- Professional services provided by a registered nurse or *licensed practical nurse*.
- Medical and surgical supplies and durable medical equipment.
- Prescribed drugs related to the *hospice* diagnosis (drugs and biologicals).
- Oxygen and its administration.
- Therapies (physical therapy, occupational therapy, speech therapy).
- Medical social service consultations
- Dietitian services.
- Family counseling services.

No *hospice* care *benefits* are provided for the following:

- Volunteers.
- Pastoral services.
- Homemaker services.
- Food or home delivered meals.

The *member* is not eligible to receive further *hospice* care *benefits* if the *member* or the *member*'s authorized representative elects to institute curative treatment or extraordinary measures to sustain life.

Immunizations and Injections (Nonpreventive)

Benefits for immunizations and injections include certain immunizations for individuals determined to be at high risk. We follow guidelines set by the CDC in determining high-risk individuals. Immunizations for travel or for employment are not covered except as required by *PPACA*.

Injectables that are "primarily self-administered" are not covered under your medical *benefit* under any circumstances, even if you are unable to self-administer. In the event you are unable to self-administer an injectable medication, only the charges for the administration of the injectable will be covered when administered and reported by an eligible *provider* in an office, *hospital outpatient*, or home setting. You can view the list of medications that we consider to be primarily self-administered by accessing the Self-Administered Medications Policy at CapitalBlueCross.com.

Infertility Services

Infertility is 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.

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), zygote intra-fallopian transfer (ZIFT), and artificial insemination are not covered.

Infusion Therapy

Infusion therapy involves the enteral, parenteral, or other instillation and administration of pharmaceuticals, biologicals and fluids. Infusion is used for a broad range of therapies such as antibiotics, chemotherapy, gene therapy, cellular therapy, pain management, and hydration.

A home *infusion therapy* provider typically provides services in the home, but a patient is not required to be homebound.

Benefits for infusion therapy include the procurement and preparation of the pharmaceuticals, biologicals and fluids; accompanying medications and solutions; supplies and equipment used to administer the infusions; and inpatient and outpatient care required to administer and monitor the infusions.

Interruption of Pregnancy

Benefits for an interruption of pregnancy include procedures for termination of a pregnancy performed through a medical or surgical procedure, including the administration of medication in a *provider's* office. Termination of the pregnancy may be nonelective.

Mammograms

A mammogram is an X-ray image examination of the breast(s) used to detect tumors and cysts, and to help differentiate benign and malignant disease.

Screening Mammogram

A screening mammogram is furnished to an individual without signs or symptoms of breast disease, for the purpose of early detection of breast cancer. *Benefits* for screening mammograms are covered under the **Preventive Care Services** section and are highlighted on the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Diagnostic Mammogram

A diagnostic mammogram is intended to provide specific evaluation of patients with a detected breast abnormality. *Benefits* for diagnostic mammograms are covered in the **Diagnostic Services, Radiology Tests** section and may be subject to *cost-sharing amounts*.

Maternity Services

Benefits for maternity services include prenatal, delivery and postpartum services provided to female *members* who are pregnant.

Prenatal Services

Benefits for prenatal services include an initial examination, tests, and a series of follow-up exams to monitor the health of the mother and fetus. Prenatal services continue up to the date of delivery.

Delivery

Benefits for deliveries include facility and professional services for vaginal and cesarean section deliveries.

Group health plans and health insurance issuers offering group health insurance coverage generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending *provider* (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, plans and issuers may not set the level of *benefits* or *out-of-pocket* costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, require that a *physician* or other healthcare *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *professional* or *facility providers*, or to reduce *out-of-pocket* costs, you may be required to obtain preauthorization. For information on preauthorization, see the **Preauthorization Program** attachment to this *Benefits Booklet*.

Postpartum Services

Benefits for postpartum services include post-delivery *hospital* services and office visits.

Medical Transport

Benefits for medical transport services include the use of specially designed and equipped vehicles to transport ill or injured patients. Medical transport services may involve ground or air transports in both emergency and nonemergency situations.

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pickup is not accessible by land, and the transport is to an acute care hospital (whether for initial transport or subsequent transfer to another facility for special care).

Emergency Ambulance

Benefits for emergency ambulance services include transportation to an acute care hospital when the circumstances leading up to the ambulance services qualify as *emergency services* and the patient is transported to the nearest acute care *hospital* with appropriate facilities for treatment of the injury or illness involved.

Nonemergency Ambulance

Benefits for nonemergency ambulance services include services only for inter-facility transportation if the circumstances leading up to the ambulance services do not qualify as *emergency services*, but are *medically necessary*. Inter-facility transportation means transportation between *hospitals* or between a *hospital* and a *skilled nursing facility*.

Transportation by way of wheelchair vans, stretcher vans, or other transportation modalities where advanced or basic life support is unnecessary are not covered. In addition, membership fees are excluded from coverage.

Mental Healthcare Services

Benefits for *mental healthcare* services include services for *mental illness* diagnoses. S*ubstance use disorder* treatment is defined under a separate *benefit*.

Inpatient Services

Benefits for *inpatient mental healthcare* services include bed, board and general *inpatient* nursing services when provided for the treatment of *mental illness*. Services provided by a *professional provider* to you as an *inpatient* for *mental healthcare* are also covered. *Benefits* include treatment received at a *residential treatment facility* when preauthorized and *medically necessary*.

Partial Hospitalization

Benefits for *partial hospitalization mental healthcare* services include the *outpatient* treatment of a *mental illness* in a planned therapeutic program during the day only or during the night only.

The *partial hospitalization* program must be approved by us or our designee. *Partial hospitalization mental healthcare* is not covered for halfway houses.

Outpatient Services

Benefits for *outpatient mental healthcare* services include the *outpatient* treatment of *mental illness* by a *hospital*, a *physician, intensive outpatient treatment program (IOP),* or another eligible *provider*.

Attention deficit/hyperactivity disorder (ADHD) is classified as a mental health condition. Treatments for ADHD are eligible under *mental healthcare benefits*. However, office visits for medication checks are considered medical visits.

Newborn Care

Benefits for newborn care include routine nursery care; prematurity services, preventive healthcare services, and services to treat an injury or illness, including care and treatment of medically diagnosed congenital defects and birth abnormalities. Refer to the **Membership Status** section for limitations on newborn care coverage.

For the first 31 days following birth, any costs for *benefits* provided to your newborn child will be applied toward your *cost-sharing amounts*. Separate *cost-sharing amounts* will not apply to your newborn child unless and until the child is separately enrolled as a dependent in accordance with the terms of this *Benefits Booklet.*

Nutrition Therapy (Counseling and Education)

Benefits for nutrition therapy include counseling and education for the treatment of diagnoses in which dietary modification is *medically necessary.* Services can include but are not limited to the treatment of diabetes heart disease, obesity and morbid obesity.

Benefits for self-management education and education relating to diet are covered when prescribed and include the following:

- Visits upon obtaining a diagnosis of a medical condition in which nutrition therapy is *medically necessary*.

- Visits when a licensed *physician* identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or when a new medication or therapeutic process relating to your treatment and/or management of the medical condition has been identified as *medically necessary* by a licensed *physician*.

Office Visits, Consultations, Telehealth and Virtual Care

You can have an office visit with an *in-network provider* in any of the following ways:

- *Telehealth* (audio and video)
- Provider office
- Hospital
- Retail facility

Visits

Inpatient – *Benefits* for *inpatient* evaluation and management include medical care services provided by a *physician* or other *professional provider* when you are a *hospital inpatient*. Medical care includes *inpatient* visits and intensive care.

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.

In certain situations, a facility fee may be associated with an *outpatient* visit to a *professional provider* where the *provider* bills separately for your use of that facility. You should consult with the *provider* of the service to determine whether a facility fee may apply to that *provider*. An additional *cost-sharing amount* may apply to the facility fee.

Consultations

Consultations are distinguished from evaluation and management services because these services are provided by a *physician* whose opinion or advice is usually requested by another *physician* regarding a specific problem.

Inpatient – *Benefits* for *inpatient* consultations include initial and follow-up *inpatient* consultation services rendered to you by another *physician* at the request of the attending *physician*.

Coverage for consultations does not include the following:

- Staff consultations required by *hospital* rules and regulations.
- Staff consultations related to teaching interns and resident medical education programs.

Outpatient – *Benefits* for *outpatient* consultations include *outpatient* office consultation visits.

Retail Clinic Services

Benefits for services performed in a retail clinic include those that, in the judgment of the *provider*, can be treated by a duly licensed or certified associated physician or allied health professional practicing within the scope of his/her licensure, certification or specialty. Retail clinic services are performed in an ambulatory medical clinic that provides a limited scope of services for preventive care or the treatment of minor injuries and illnesses. The clinic is open to the public for walk-in, unscheduled visits during all open hours, and offers significant extended hours, which may include evenings, holidays and weekends. *Benefits* for retail clinic services are calculated at the same *benefit* level as *professional provider* outpatient office visits.

Telehealth

Members' cost sharing for *telehealth* services is the same as for in-person visits with that provider. Not all services are eligible for *telehealth* coverage.

For more information on the types of providers approved for *telehealth*, visit CapitalBlueCross.com.

Telehealth coverage does not include the following:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results
- Nurse call centers/advice centers
- Services involving remote invasive treatment and/or diagnostic testing
- Group counseling

Capital BlueCross Virtual Care

Capital BlueCross Virtual Care offers *medically necessary* services to you where the interaction between you and the provider is through a secure, interactive real-time, audio and video telecommunications system on a secure platform hosted by our contracted vendor.

Through our Virtual Care platform, accessible via an application or website, you can access virtual visits through our contracted vendor. Available providers include physicians, certified registered nurse practitioners (CRNPs), physician assistants (PAs), within the specialties of family medicine, pediatrics, internal medicine, and psychiatrists and other eligible providers who are licensed psychologists, social workers, behavioral specialists, marriage counselors, certified psychiatric nurses and family therapists.

Capital BlueCross Virtual Care benefits are limited to the following *medically necessary* services:

- Diagnosis and management of acute minor illness that do not typically require direct hands-on provider examination.
- Individual behavioral health diagnosis, counseling, and treatment. (Benefits do not include group counseling.)
- Treatment for general wellness concerns
- Treatment for nicotine cessation.

Capital BlueCross Virtual Care coverage does not include:

- Email or telephone communications that are not video enabled for reporting or discussions of laboratory or other diagnostic and screening results.
- Nurse call centers/advice centers.
- Services involving remote invasive treatment and/or diagnostic testing.
- Group counseling.

For information on accessing Capital BlueCross Virtual Care, visit CapitalBlueCross.com.

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** attachment to this *Benefits Booklet*. These guidelines are periodically updated to reflect current recommendations from organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Service Task Force (USPSTF), and Advisory Committee on Immunization Practices (ACIP). This document is not intended to be a complete list of preventive care services and is subject to change.

Pediatric

Benefits for pediatric preventive care include routine physical examinations, childhood immunizations, and tests. For more information, refer to the **Schedule of Preventive Care Services** attachment.

Adult

Benefits for adult preventive care include routine physical examinations, immunizations, and tests. *Benefits* also include specific women's preventive services as mandated by law. For more information, refer to the **Schedule of Preventive Care Services** attachment.

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** attachment due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. We follow guidelines set by the CDC 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*.

Prosthetic Appliances

Prosthetic appliances replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part that is lost or impaired as a result of disease, injury or congenital deficit regardless of whether they are surgically implanted or worn outside the body. The surgical implantation or attachment of covered prosthetics is considered *medically necessary*, regardless of whether the covered prosthetic is functional (i.e., irrespective of whether the prosthetic improves or restores a bodily function.)

Benefits for prosthetics include the purchase, fitting, necessary adjustment, repairs, and replacements after normal wear and tear of the most cost-effective prosthetic devices and supplies. Repair costs cannot exceed the purchase price of a prosthetic device. Prosthetics are limited to the most cost-effective *medically necessary* device required to restore lost body function.

Wigs are covered prosthetics in certain cases and may be subject to a *benefit lifetime maximum*. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered. Glasses, cataract lenses, contact lenses, and scleral shells prescribed after cataract or intra-ocular *surgery* **without** a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

The replacement of cataract lenses (except when new cataract lenses are needed because of prescription change) and certain dental appliances are not covered.

Skilled Nursing Facility

Benefits for *skilled nursing facilities* include services provided when you require *inpatient skilled nursing services* on a daily basis and these *skilled nursing services* are provided in accordance with a *physician*'s order. We must concur with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

Substance Use Disorder Services

Detoxification – Inpatient

Benefits for *inpatient* detoxification include services to assist an alcohol and/or drug intoxicated or dependent *member* in the elimination of the intoxicating alcohol or drug as well as alcohol or drug dependency factors while minimizing the physiological risk to the *member*.

Services must be performed in a facility licensed by the state in which it is located.

Rehabilitation

Benefits for *substance use disorder* rehabilitation include services to assist you with a diagnosis of *substance use disorder* in overcoming your addiction. You must be detoxified before rehabilitation will be covered. A *substance use disorder* treatment program provides rehabilitation care.

Inpatient — *Benefits* for *inpatient substance use disorder* rehabilitation include: bed, board and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to you as an *inpatient* for *substance use disorder* 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)*, *partial hospitalization* or through *medication assisted treatment (MAT)*.

Surgery

Benefits for *surgery* include facility and professional services for preoperative care, surgical procedures, and post-operative care.

Surgical Procedure

Benefits for surgical procedures include surgical services required for the treatment of a disease or injury when performed by a *physician* or other *professional provider* in an *inpatient hospital* or *outpatient* setting. Certain rules and guidelines apply if an additional surgeon or multiple surgeries are needed.

Outpatient Surgery

Outpatient surgery may be performed in an acute care *hospital* or *ambulatory surgical facility*. *Benefits* for *ambulatory surgical facilities* include those *outpatient surgeries* that, in the judgment of the provider,

are not life-threatening, can be provided in a facility other than an acute care *hospital*, and are performed at an *ambulatory surgical facility* by a duly licensed associated *physician* or allied health professional practicing within the scope of his/her licensure and specialty. Facility charges for *outpatient surgeries* performed in an acute care *hospital* may be subject to higher *cost-sharing amounts*.

Anesthesia Related to Surgery

Benefits for the administration of anesthesia related to *surgery* include services ordered by the attending *professional provider* and rendered by a *professional provider*, including the operating *physicians* under certain circumstances, but other than the assistant at *surgery*, or the attending *physician*.

Benefits also include hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia in a hospital or ambulatory surgical facility setting for noncovered dental procedures or noncovered oral surgery for an eligible dental patient, provided we determine the services are *medically necessary,* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. An eligible dental patient is a patient who is seven years of age or younger or developmentally disabled. Anesthesia and all related *benefits* for eligible dental patients are subject to all applicable *cost-sharing amounts.*

Mastectomy and Related Services

A mastectomy is the surgical removal of all or part of a breast. *Benefits* for a mastectomy include a mastectomy performed on an *inpatient* or *outpatient* basis and *surgery* performed to reestablish symmetry or alleviate *functional impairment*, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. *Reconstructive surgery* to reestablish symmetry is covered for the unaffected breast as well as the affected breast. *Benefits* are also provided for physical complications due to the mastectomy such as lymphedema.

Oral and Orthognathic Surgery

Benefits for oral *surgery* include surgical extractions of full or partial bony impactions, root recovery, surgical exposure of impacted or unerupted teeth, surgical excisions (e.g., cysts, tori, exostosis), to improve function and lingual frenulum repairs.

Orthognathic *surgery* is limited to conditions resulting in significant *functional impairment*, fractures and dislocations of the face or jaw, and when major disease, trauma or surgery results in insufficient boney structure to support dentures or other oral prosthetics in order to chew. Orthognathic surgery is also covered for the first 31 days after birth for the treatment of congenital birth defects, even where *functional impairment* is not present.

Anesthesia charges associated with oral surgery are covered for an eligible dental patient when we determine the anesthesia is *medically necessary* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. An eligible dental patient is a patient who is seven years of age or younger or developmentally disabled. Anesthesia and all related *benefits* for an eligible dental patient are subject to all applicable *cost-sharing amounts.*

Other Surgeries

Benefits for other specialized surgical procedures include the following services:

- Routine neonatal circumcisions.

- Sterilization procedures.

Therapy Services

Rehabilitative Services are healthcare services and devices that are provided to help a person regain, maintain, or improve skills or functioning for daily living that have been acquired but then lost or impaired due to illness, injury, or disabling condition.

Habilitative services are healthcare services and devices that are provided for a person to attain, maintain, or improve skills or functioning for daily living that were never learned or acquired due to a disabling condition (for example, therapy for a child who isn't walking or talking at the expected age).

Benefits for therapy services include services provided for evaluation and treatment of your illness or injury when an expectation exists that the therapy will result in significant, measurable improvement in your level of functioning within a reasonable period of time appropriate to your condition.

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 FDA guidelines.

Benefits for chemotherapy include chemotherapy drugs and the administration of these drugs provided in either an *inpatient* or *outpatient* setting.

Manipulation Therapy

Benefits for manipulation therapy include treatment involving movement of the spinal or other body regions when the services rendered have a direct therapeutic relationship to the patient's condition, are performed for a musculoskeletal condition, and there is an expectation of restoring the patient's level of function lost due to this condition.

Benefits include maintenance manipulation therapy for chronic pain management.

Occupational Therapy

Benefits for occupational therapy include the evaluation and treatment of a physically disabled person by means of constructive activities designed to promote the restoration of the ability to satisfactorily accomplish the ordinary tasks of daily living.

Benefits for occupational therapy include rehabilitative and habilitative services.

Physical Therapy

Benefits for physical therapy include evaluation and treatment by physical means or modalities, such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and

the use of therapeutic exercises or activities performed to relieve pain and restore a level of function following disease, illness or injury.

Benefits for physical therapy include rehabilitative and habilitative services.

Radiation Therapy

Benefits for radiation therapy (also known as radiation oncology or therapeutic oncology) include the *inpatient* or *outpatient* treatment of a disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, and radium or radioactive isotopes, including the cost of the radioactive material.

Respiratory/Pulmonary Rehabilitation Therapy

Benefits for respiratory therapy include the treatment of acute or chronic lung conditions using intermittent positive breathing (IPPB) treatments, chest percussion, and postural drainage.

Pulmonary therapy includes treatment through a multi-disciplinary program. This program combines physical therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

Maintenance respiratory and pulmonary therapy is not covered.

Speech Therapy

Benefits for speech therapy include those services necessary for the evaluation, diagnosis, and treatment of certain speech and language disorders as well as services required for the diagnosis and treatment of swallowing disorders.

Benefits for speech therapy include rehabilitative and habilitative services.

Transplant Services

Benefits for transplant services are provided for *inpatient* and *outpatient* services related to human organ and tissue transplants that we have found not to be *investigational*.

Pre-Transplant Evaluation

Benefits for pre-transplant evaluations include testing performed to determine donor compatibility, pre-operative testing, medical examination of the donor in preparation for harvesting the organ or tissue, and organ bank registry fees. Costs associated with registration, evaluation, or duplicate services at more than one transplantation institution are not covered. If you assume financial responsibility for obtaining and maintaining a duplicate organ listing at an additional facility and the organ becomes available at that location, the transplantation may be eligible for coverage.

The cost of screening is covered up to the cost of the identification of one viable donor candidate. Additional community or global screenings for a donor are not covered.

Acquisition and Transplantation

Benefits for acquisition and transplantation include the removal of an organ from a living donor or cadaver and implantation of the organ or tissue into a recipient.

- When the transplant requires surgical removal of the donated part from a living donor and we cover both the recipient and donor, we provide *benefits* to both, each pursuant to the terms of each person’s respective contract.

- If we cover only the transplant recipient, we provide *benefits* for the recipient and for the donor, but only to the extent that donor benefits are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's coverage.

If we cover the transplant recipient and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

Donor charges accumulate towards the recipient's *benefit period maximums* or any other applicable limits and maximums.

Payment will not be made for the purchase of human organs that are sold rather than donated to the recipient.

Transplantation of placental umbilical cord blood stem cells from related or unrelated donors may be considered *medically necessary* in patients with an appropriate indication for allogeneic stem-cell transplant.

Collection and storage of cord blood from a neonate may be considered *medically necessary* when an allogeneic transplant is imminent in an identified recipient with a diagnosis that is consistent with the possible need for allogeneic transplant.

Transplantation of cord blood stem cells from related or unrelated donors is considered *investigational* in all other situations.

Post-Transplant Services

Benefits for post-transplant services include post-surgical care.

Blue Distinction Centers for Transplant (BDCT)

Blue Distinction Centers for Transplant are a cooperative effort of the BlueCross and/or BlueShield 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 you and one support companion. Items that are not covered include, but are not limited to, alcohol, tobacco, car rental, entertainment, expenses for persons other than you and your 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 Services

Benefits for hearing services include only hearing testing for diagnostic purposes.

Hearing aids and exams for the purchase and fitting of *hearing aids* are not covered.

Foot Care

Benefits for nonroutine foot care include surgical treatment of structural defects or anomalies such as fractures or hammertoes. *Benefits* also include surgical removal of ingrown toenails and bunions when provided for specific medical diagnoses. An injectable local anesthetic must be used in order for a foot procedure to be considered “toenail surgery”.

Routine foot care services are not covered unless the services are *medically necessary* for specific medical diagnoses.

Orthodontic Treatment of Congenital Cleft Palates

Benefits for orthodontics include orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Routine Costs Associated with Approved Clinical Trials

If a *member* is eligible to participate in an *approved clinical trial* (according to the trial protocol), with respect to treatment of cancer or other life-threatening disease or condition, and the member’s *provider* has concluded the *member’s* participation in the trial would be appropriate, *benefits* for *routine costs associated with approved clinical trials* will be covered.

Vision Care for Illness or Accidental Injury

Benefits for vision services include only eye care that is *medically necessary* to treat a condition arising from an illness or accidental injury to the eye. Covered services include *surgery* for medical conditions, symptomatic conditions and trauma. Vision screening related to a medical diagnosis, only for diagnostic purposes, is also covered.

When cataract *surgery* is performed, *benefits* for vision services include lens implants, with limitations, as described in the **Prosthetic Appliances** section.

Routine eye care examinations, refractive lenses (glasses or contact lenses) and routine tests are not covered. Replacement refractive lenses (glasses or contact lenses) prescribed for use with an intra-ocular lens transplant are not covered.

EXCLUSIONS

Except as specifically provided in this *Benefits Booklet* or as we are required to provide based on state or federal law, we will not provide *benefits* for the following services, supplies, equipment, or charges:

Anesthesia	• Anesthesia when administered by the assistant to the operating *physician* or the attending *physician*
Blood and Administration	• Prophylactic blood, cord blood or bone marrow storage to be used in the event of an accident or unforeseen *surgery* or transplant
Clinical Trials	• Services or supplies that we consider to be *investigational*, except routine costs associated with a*pproved clinical trials* Routine costs for clinical trials do not include any of the following and are therefore excluded from *coverage*: • The investigational drug, biological product, device, medical treatment, or procedure itself • The services and supplies provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient • The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial • Your travel expenses
Convenience	• Personal hygiene, comfort, 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) • Radios and televisions • Beauty or barber shop services • Incontinence supplies, deodorants • Guest trays, chairlifts, elevators, or any other modification to real or personal property, whether or not recommended by a *provider* • Spa or health club memberships • Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments such as premiums, which entitle those enrolled to services; repairs; or replacement of devices, equipment, or parts without charge or at a reduced charge
Cosmetic Surgery	• Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the

	functioning of the body part can be expected, except as otherwise required by law. This exclusion does not apply to cosmetic procedures or services related to cosmetic procedures performed to correct a deformity resulting from *birth defect* or accidental injury. For purposes of this exclusion, prior *surgery* is not considered an accidental injury.
Court Ordered Services	• Court ordered services when not *medically necessary* or not a covered *benefit*
Custodial Care	• *Custodial care*, domiciliary care, residential care, protective care, and supportive care, including educational services, rest cures, convalescent care, or respite care not related to *hospice* services
Dental Care	• All dental services after stabilization in an emergency following an accidental injury, including but not limited to, oral *surgery* for replacement teeth, oral prosthetic devices, bridges, or orthodontics • Services directly related to the care, filling, removal, or replacement of teeth; orthodontic care; treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth; or for dental implants, except where mandated by law or as specifically provided in this *Benefits Booklet*
Durable Medical Equipment (DME)/Supplies	• Back-up or secondary DME and prosthetic appliances, except ventilators • DME requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home • Replacement of lost or stolen DME, including prosthetic appliances, within the expected useful life of the originally purchased DME • Continued repair of DME after its useful life is exhausted • Replacement of defective or nonfunctional DME when the manufacturer's warranty covers the equipment • Upgrade or replacement of DME when the existing equipment is functional, except when there is a change in your health such that the current equipment no longer meets your medical needs • Modifications and adjustments to and accessories for DME, orthotics, prosthetics, and diabetic shoes that do not improve the functionality of the equipment • DME intended for use in a facility (*hospital* grade equipment) • Home delivery, education, and set-up charges associated with purchase or rental of DME, as such charges are not separately reimbursable and are considered part of the rental or purchase price • Items including but not limited to items used as safety devices and for elastic sleeves (except where otherwise required by law), thermometers, bandages, gauze, dressings, cotton balls, tape,

	adhesive removers, face masks, replacement batteries or alcohol pads • Supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices
Education	• Services provided at unapproved sites, for a *member's* individualized education program (IEP), or as part of a *member's* education, except as may be required by statue or explicit legal requirement
Eligibility	• Services incurred prior to your *effective date of coverage* • Services incurred after your *coverage* termination date except as provided for in this *Benefits Booklet*
Eligible Provider	• Services not billed and either performed by, or under the supervision of, an eligible *provider* • Services rendered by a *provider* who is a member of your *immediate family* • Telephone and electronic consultations, including *virtual services*, between you and a *provider*, except as otherwise provided in this *Benefits Booklet* • 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*
Experimental or Investigational	• Services or supplies we consider to be *investigational,* except where otherwise required by law
Food/ Nutritional Support	• Enteral nutrition due to lactose intolerance or other milk allergies • Blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Benefits Booklet* • All other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Benefits Booklet*
Foot Care	• Routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except *surgery* for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints;
Genetic Testing	• At-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic

	testing performed primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*
Hearing Aids	• Hearing aids, examinations for the prescription or fitting of hearing aids, and all related services
Immunizations	• Immunizations required for travel or employment except as required by law
Infertility Services	• Donor services related to assisted fertilization • Procedures to reverse sterilization • Any treatment or procedure leading to or in connection with assisted fertilization, such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and artificial insemination except as provided in this *Benefits Booklet* • For *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
Interruption of Pregnancy/Abortion	• For elective terminations of pregnancy
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by our Medical Director(s) or his/her designee(s)
Medicare	• Items or services paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws for any *member* who is enrolled in *Medicare*. This exclusion does not apply to the extent the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare*.
Medications	• All prescription and *over-the-counter* drugs dispensed by a pharmacy or *provider* for your *outpatient* use, whether or not billed by a *facility provider*, except for allergy serums, mandated pharmacological agents used for controlling blood sugar, FDA-approved drugs for the treatment of substance use disorder, and where otherwise required by law • All prescription and *over-the-counter* drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan that we approved
Military Services	• Services received by veterans and active military personnel at facilities operated by the U.S. Department of Veterans Affairs or

	by the Department of Defense, unless payment is required by law
Miscellaneous	• Care of conditions that federal, state, or local law requires to be treated in a public facility • Any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • Services you receive from a dental or medical department maintained by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar person or group • Charges for: failure to keep a scheduled appointment with a *provider*, completion of a claim or insurance form, obtaining copies of medical records, your decision to cancel a *surgery*, or hospital-mandated on-call service • Charges that exceed the *allowable amount*, except as otherwise provided for in this *Benefits Booklet* • *Cost-sharing amounts* you must pay as outlined in this *Benefits Booklet* • Autopsies or any other services rendered after a *member's* death • Any services related to or rendered in connection with a noncovered service, including but not limited to anesthesia and diagnostic services • Any other service or treatment, except as provided in this *Benefits Booklet*
Motor Vehicle Accident	• Cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy
Oral Surgery	• Oral *surgery* except as specifically provided in this *Benefits Booklet*
Prosthetics	• Prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device • Wigs and other items intended to replace hair loss due to male or female pattern baldness
Physical Exams	• Routine examination, counseling services, testing, screening, immunization, treatment or preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to: pre-marital examinations; employment or occupational screenings; or physicals for college, camp, sports, or travel
Sexual Dysfunction	• Treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic

	disease or injury
Sports Medicine	• Sports medicine treatment or equipment intended primarily to enhance athletic performance
Surgery	• All types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present
Therapy Services	• For acupuncture • Biofeedback therapy • Cognitive rehabilitation therapy, except when provided as 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) • Maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law • Occupational therapy or physical therapy for work hardening, vocational and prevocational assessment and training, and functional capacity evaluations, as well as this therapy's use towards enhancement of athletic skills or activities • All rehabilitative therapy, other than as described in the *Benefits Booklet*, including but not limited to play, music, hippotherapy, and recreational therapy
Temporomandibular Joint Syndrome	• 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 or treatment of TMJ caused by physical trauma resulting from an accident • Intra-oral reversible prosthetic devices or appliances regardless of the cause of TMJ
Transplant	• Services related to organ donation where you serve as an organ donor to a nonmember • Transplant services where human organs were sold rather than donated and for devices functioning as total artificial organs that are not approved by the FDA
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this *Benefits Booklet*
Vision Care	• Routine eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to refractive lenses prescribed for use with an intra-ocular lens transplant

	• Routine vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses. • Surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy, and refractive keratoplasty
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared
Weight Loss	• *Inpatient* stays to bring about nonsurgical weight reduction
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy or coverage, or the applicable law.

MEDICAL CLINICAL MANAGEMENT PROGRAMS

We offer Clinical Management programs intended to provide a personal touch to the administration of your *benefits* available under this *coverage*. We focus program goals on providing you with the skills necessary to become more involved in the prevention, treatment and recovery processes for your specific condition, illness or injury.

Clinical Management programs include:

- Utilization Management
- Population Health Management
- Quality Improvement

All of our standard products include the full array of these programs.

Utilization Management

The Utilization Management program is a primary resource to identify *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

Your *coverage* provides *benefits* only for services we or our designee determine to be *medically necessary* as defined in the **Definitions** section.

When *preauthorization* is required, we, or our designee, determine *medical necessity* before the service is provided. However, when *preauthorization* is not required, a service may still undergo a *medical necessity* review and must still be considered *medically necessary* to be eligible for coverage.

An *in-network provider* will accept our determination of *medical necessity*. You will not be billed by an *in-network provider* for services that *we* determine are not *medically necessary*.

An *out-of-network provider* is not obligated to accept our *preauthorization* denial or determination of *medical necessity*, and therefore, may bill you for services determined not to be *medically necessary*. You are solely responsible for payment of such services and can avoid this responsibility by choosing an *in-network provider*.

Even if an *in-network provider* recommends that you receive services from an *out-of-network provider*, you are responsible for payment of all services determined by us to be not *medically necessary*.

NOTE: A *provider's* belief that a service is appropriate for you does not mean the service is covered. Likewise, a *provider's* recommendation to you to receive a given healthcare service does not mean that the service is *medically necessary* and/or a covered service.

You or the *provider* may contact our *Clinical Management* department to determine whether a service is *medically necessary*. The criteria for *medical necessity* determinations, including those made with respect to mental *healthcare* or *substance use disorder benefits*, will be made available to any current *member* or *in-network provider* upon request.

Investigational Treatment Review

Your *coverage* does not include services we determine to be *investigational* as defined in the **Definitions** section.

However, we recognize that situations occur when you elect to pursue *investigational* treatment at your own expense. If you receive a service we consider to be *investigational*, you are solely responsible for payment of these services and the noncovered amount will not be applied to the *out-of-pocket maximum* or *deductible,* if applicable.

You or a *provider* may contact us to determine whether we consider a service to be *investigational*.

Preauthorization

Preauthorization is a process for evaluating requests for services prior to the delivery of care. The general purpose of the *preauthorization* program is to help you receive the following:

- Medically appropriate treatment to meet individual needs
- Care provided by *in-network providers* delivered in an efficient and effective manner
- Maximum available *benefits*, resources, and coverage.

In-network providers are responsible for obtaining required *preauthorizations*.

However, if an *out-of-network provider* is used, you are responsible for obtaining the required *preauthorization;* failure to *preauthorize* may result in a denial of *coverage*.

You should refer to the **Preauthorization Program** attachment to this *Benefits Booklet* for information on this program. You should carefully review this attachment to determine whether services you wish to receive must be preauthorized by us and for instructions on how to obtain *preauthorization*. This listing may be updated periodically.

A *preauthorization* decision is generally issued within 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 our experienced registered nurses and board-certified physicians who evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in *inpatient* settings (acute care hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals). In addition, the program is designed to facilitate identification and referral of *members* to other Clinical Management Programs, such as Population Health 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 day of receiving all necessary information.

Discharge Planning – Discharge planning is performed by concurrent review nurses who communicate with hospital staff 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

Our 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 we receive a claim for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred any of the following ways:

- Under *coverage* that does not include the *preauthorization* program.
- In situations such as an emergency when securing an authorization within required time frames is not practical or possible.
- For services that are potentially *investigational* or cosmetic in nature.
- For services that have not complied with *preauthorization* requirements.

We issue retrospective review decisions generally within **30** calendar days of receiving all necessary information.

If a retrospective review finds a procedure to not be *medically necessary*, you may be liable for payment to the *provider* if the *provider* is *out-of-network*.

Population Health Management

Our Population Health Management programs improve member health through a seamless set of interdisciplinary interventional strategies. Our goal is to meet you wherever you are in your healthcare journey — healthy, rising risk, chronic or catastrophically ill. At each stage, we provide appropriate educational and clinical services to improve health and quality of life. To meet our population health management strategies, we deliver the following services and programs:

Care Management

Our Care Management programs are proactive, and designed for *members* with chronic, acute and/or complex medical needs who could benefit from additional support with coordinating their care.

Programs include, but are not limited to the following:

- Complex Case Management
- Chronic Condition/Disease Management
- Maternity Management
- Oncology Case Management
- Transitions of Care
- Transplant Case Management

Complex Case Management

The Complex Case Management program is an interdisciplinary service encompassing a wide variety of resources, information, and specialized assistance for *members* identified as follows*:*

- With complex medical needs.
- At risk for future adverse health events.

The Complex Case Management resources can help members manage complex health needs and improve quality of life.

Chronic Condition/Disease Management

The Chronic Condition/Disease Management program is an interdisciplinary, collaborative program that assesses the health needs of *members* with chronic conditions and provides customized member education, counseling, and information to increase the *member's* ability to self-manage their condition(s).

The goal of chronic condition management is to improve the following:

- Member and caregiver knowledge and self-management.
- Resource utilization.
- Quality of life through achieving and maintaining a steady state of health.
- Achieve and maintain a steady state of health.

Although the program has many areas of concentration, self-management action plans, education, knowledge enhancement, and medication optimization and adherence are of particular importance.

Conditions addressed in the program could include, but are not limited to, adult and pediatric asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), adult and pediatric diabetes, heart failure, and hypertension.

Maternity Management

We offer a comprehensive Maternity Management program that provides education, care coordination, materials and support to pregnant women.

The focus of the Maternity Management program is to help pregnant members have a healthy pregnancy and baby through a variety of interventions, based upon population and individual needs.

Using a custom predictive modeling tool, pregnant members are stratified into high and low-risk categories, as follows:

- **Individuals stratified as high risk** receive direct telephone outreach from a nurse experienced in all phases of pregnancy and deliver, including high-risk labor and delivery, newborn care and post-partum care.
- **Individuals stratified as low risk** receive an automated outbound call that offers health education information during each trimester of their pregnancy, as well as a follow up post-partum call. Members may request to be warm transferred to our clinical staff or request a call back from a clinician at any time.

Oncology Case Management

Registered nurses, experienced in cancer care and advanced care planning, provide assessment and support to *members* at all stages of adjustment to a cancer diagnosis.

Transitions of Care

The Transitions of Care program assists *members* in understanding their post-discharge treatment plan and thereby helps prevent avoidable complications and readmissions.

Transplant Case Management

Registered nurses experienced in transplant care provide assessment, education, and support during the transplant process. Core goals of this program include education and support regarding treatments, medical benefit plan, and Blue Distinction Centers for Transplants®.

Health Education and Wellness

Our Health Education and Wellness programs are provided through various areas/services at Capital BlueCross. We believe that motivating individuals to adopt healthier lifestyles results in better outcomes when individuals have access to comprehensive and accurate health and wellness information.

Quality Improvement Program

The Quality Improvement program is a multidisciplinary program we designed to help you get accessible quality care and services. The program provides for the monitoring, evaluation, measurement, and reporting on the quality and safety of medical care, programs, and services.

The scope of our Quality Improvement program encompasses all aspects of the care and services provided to our members and includes, but is not limited to the following:

- Improvement in our members' health and experience of care.
- Coordination and continuity of programs and services across all levels of care.
- Facilitation of appropriate accessibility and availability of care and services.
- Monitoring the effectiveness of the care and services our members receive.
- Evaluation and investigation of complaints and clinical appeals.
- Identification and evaluation of and intervention (as necessary) for all potential quality issues.
- Conducting and analyzing member satisfaction surveys.
- Monitoring of provider practice patterns and ensuring they are meeting our members' needs.
- Compliance with all regulatory and accrediting standards.

How We Evaluate New Technology

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. We strive to remain knowledgeable about recent medical developments and best practice standards to facilitate processes that keep our medical policies up-to-date. A committee of local practicing *physicians* representing various specialties evaluates the use of new medical technologies and new applications of existing technologies. This committee is known as the Clinical Advisory Committee. The *physicians* on this committee provide clinical input to us concerning our medical policies, with an emphasis on community practice standards. The Committee, along with our Medical Directors and Medical Policy staff, look at issues such as the effectiveness and safety of the new technology in treating various conditions, as well as the associated risks.

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, *specialists* and professionals with expertise in the technology, and government agencies such as the

FDA, the National Institutes of Health, and the CDC. The five key criteria used by the Committee to evaluate new technology are:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational setting.

After reviewing and discussing all of the available information and evaluating the new technology based on the criteria listed above, the Clinical Advisory Committee makes final determinations concerning medical policy after assessing *provider* and *member* impacts of recommended policies.

Our medical policies are developed to assist us in administering *benefits* and do not constitute medical advice. Although the medical policies may assist you and your *provider* in making informed healthcare decisions, you and your treating *providers* are solely responsible for treatment decisions. *Benefits* for all services are subject to the terms of this *coverage*.

Alternative Treatment Plans

Notwithstanding anything under this *coverage* to the contrary, the *contract holder*, in its sole discretion, may elect to provide *benefits* pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require *preauthorization* from *Capital*. All decisions regarding the treatment to be provided to a *member* remain the responsibility of the treating *physician* and the *member*.

If the *contract holder* elects to provide alternative *benefits* 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

This section explains when and why your coverage with us may end.

Termination of Group Contract

When the *group contract* ends, *coverage* with us is automatically terminated for all *members* in that group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of Coverage for Members

You cannot be terminated based on health status, healthcare need, or the use of our adverse benefit determination appeal procedures.

However, there are situations in which a *member's coverage* is terminated even though the *group contract* is still in effect. These situations include, but are not limited to the following:

- *Subscriber* – *Coverage* ends on the date a *subscriber* is no longer employed by, or 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 the *dependent* spouse ceases to be eligible under this *coverage*.
- Child – *Coverage* of a child ends on the date the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child – *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* disabled child.

In addition, *coverage* terminates for *members* if they participate in fraudulent behavior or intentionally misrepresent material facts, including but not limited to the following:

- Using an ID card to obtain goods or services:
  - Not prescribed or ordered for the *subscriber* or the *subscriber's dependents*.
  - To which the *subscriber* or the *subscriber's dependents* are otherwise not legally entitled.
- Allowing any other person to use an ID card to obtain services. If a dependent allows any other person to use an ID card to obtain services, coverage of the dependent who allowed the misuse of the ID card is terminated.
- Knowingly misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under

this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA is a federal law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage*.

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA* 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 the following:

- Termination of employment.
- Ineligibility to remain on this *coverage* due to a divorce, reaching a specific age limit, or a change in job status.
- Termination of the *group contract* due to the *contract holder's* nonpayment of *fees*.

We are not liable for the cost of *benefits* provided to *members* after the date of termination.

Enrollment forms are available from our Member Services department and can be obtained by calling the Member Services number located on the back of the *member ID card*.

APPLYING FOR INDIVIDUAL PRODUCTS IS THE *MEMBER'S* RESPONSIBILITY.

Coverage for Medicare-Eligible Members

If a *member* is no longer eligible for this *coverage*, is age 65 or older, and is enrolled in *Medicare* Parts A and B; the *member* can enroll in a *Medicare* Supplemental or a *Medicare* Advantage product offered by the Capital BlueCross family of companies.

Enrollment forms are available from our Member Services department and can be obtained by calling the Member Services number located on the back of the *member ID card*.

APPLYING FOR *MEDICARE* SUPPLEMENTAL OR *MEDICARE* ADVANTAGE COVERAGE IS THE *MEMBER'S* RESPONSIBILITY.

Coverage for Totally Disabled Members

Benefits will be furnished to a totally disabled *subscriber* or a totally disabled *dependent* for services **directly related** to the condition that caused this total disability and for no other condition, illness, disease, or injury if the *subscriber* or the *dependent* is totally disabled on the date *coverage* is terminated.

Totally Disabled (or Total Disability) is a condition resulting from disease or injury in which, as determined by our Medical Director, one of the following conditions may exist:

- The individual is unable to perform the substantial and material duties of his/her regular occupation and is not in fact engaged in any occupation for wage or profit.
- If the individual does not usually engage in any occupation for wage or profit, the *member* is substantially unable to engage in the normal activities of an individual of the same age and sex.

If an eligible *member* meets the definition of totally disabled, extended disability *benefits* are provided, based on whichever occurs first:

- Up to a maximum period of 12 consecutive months.
- Until the maximum amount of benefits has been paid.
- Until the total disability ends.
- Until the *member* becomes covered, without limitation as to the disabling condition, under any other coverage.

A *member* must contact Member Services to start the application process for coverage under this provision.

APPLYING FOR COVERAGE FOR TOTALLY DISABLED *MEMBERS* IS THE *MEMBER'S* RESPONSIBILITY.

CLAIMS REIMBURSEMENT FOR MEDICAL BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for healthcare services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which *we* receive a claim for *benefits* is dependent upon the type of *provider* from which you receive services. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

In-Network Providers

When you receive services from an *in-network provider*, show your *member ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* — after applicable *cost-sharing amounts*, if any are deducted— is made directly to the *in-network provider*.

Out-of-Network Providers

If you visit an *out-of-network provider*, you may be required to pay for the service at the time it is rendered. Although many *out-of-network providers* file claims on behalf of our *members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Unless otherwise agreed to by us, payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made.

Out-of-Area Providers

If you receive services from a *provider* outside of our *service area,* and the *provider* is a member of the local Blue Plan, show your *member ID card* to the *provider*. The *provider* will file a claim with the local Blue Plan that will in turn electronically route the claim to us for processing. We apply the applicable *benefits* and *cost-sharing amounts* to the claim. We send this information back to the local Blue Plan and they make payment directly to the *in-network provider*.

Allowable Amount

For *professional providers* and *facility providers*, we base the *benefit* payment amount 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 your *cost-sharing amount* obligations.

Filing a Claim

If it is necessary for you to submit a claim to us, be sure to request an itemized bill from your healthcare *provider*. Submit the itemized bill to us with a completed *Capital* BlueCross Medical Claim Form.

Obtain a copy of this claim form at CapitalBlueCross.com or by calling Member Services at the number found on the back of your *member ID card*. Your claim will process more quickly when this form is

used. A separate claim form must be completed for each person enrolled for *coverage* who received medical services.

A Special Note about Medical Records

To determine if services are *benefits* covered under your *coverage*, you (or the *provider* on your behalf) may need to submit medical records, *physician* notes, or treatment plans. We will contact you and/or the *provider* if we need additional information to determine if the services and/or supplies received are *medically necessary*.

Where to Submit Medical Claims

Submit your claims with a completed Capital BlueCross Medical Claim Form and an itemized bill to the following address:

Capital BlueCross
PO Box 211457
Eagan, MN 55121

If you need help submitting a medical claim call Member Services at the number on the back of your *member ID card* (TTY: **711**)**.**

Out-of-Country Claims

There are special claim filing requirements for services received outside of the United States.

Inpatient Hospital Claims

Claims for *inpatient hospital* services arranged through the Blue Cross Blue Shield Global Core service center require you to pay only the usual *cost-sharing amounts*. The *hospital* files the claim for you. If you receive *inpatient hospital* care from an *out-of-network hospital* or services that were not coordinated through the service center, you may have to pay the *hospital* and submit the claim to the service center at P.O. Box 2048, Southeastern, PA 19399.

Professional Provider Claims

For all *outpatient* and professional medical care, you pay the *provider* and then submit the claim to the Blue Cross Blue Shield Global Core service center at P.O. Box 2048, Southeastern, PA 19399. The claim should be submitted showing the currency used to pay for the services.

International Claim Form

There is a specific claim form that must be used to submit international claims. Itemized bills must be submitted with the claim form. The international claim form can be accessed at CapitalBlueCross.com.

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

All claims must be submitted within 12 months from the date of service with the exception of claims from certain state and federal agencies.

Time Frames Applicable to Medical Claims

If your claim involves a medical service or supply that has not yet been received (pre-service claim), we will process the claim within 15 days of receiving the claim.

If your claim involves a medical service or supply that was already received (post-service claim), we will process the claim within 30 days of receiving the claim.

We may extend the 15-day or 30-day period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Special Time Frames Applicable to "Urgent Care" Claims

An urgent care claim is one in which application of the non-urgent time periods for making a determination could seriously jeopardize your life or health, your ability to regain maximum function or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

We will notify you of the decision on an urgent care claim as soon as possible but not later than 72 hours after receipt of the claim, unless information is insufficient to make a determination of coverage.

If such is the case, we will notify you of the additional information needed within 24 hours of receipt of the claim.

- We will give you a reasonable amount of time but no less than 48 hours to submit the additional necessary information.
- We will notify you of the decision on such an urgent care claim as soon as possible but not later than 48 hours after receipt of the additional information or the end of the period allowed to you to provide the information, whichever is earlier.

Special Time Frames Applicable to "Concurrent Care" Claims

Medical circumstances may arise under which we approve an ongoing course of treatment to be provided to you over a period of time or number of treatments. If you or your *provider* believe that the period of time or number of treatments should be extended, follow the steps described below.

If you believe that any delay in extending the period of time or number of treatments would jeopardize your life, health, or ability to regain maximum function, you must request an extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. You must make a request for an extension by calling Member Services at the number listed on the back of your member ID card. We will review your request and will notify you of our decision within 24 hours after receipt.

If you are dissatisfied with the outcome of your request, you may submit an appeal. Refer to the **Appeal Procedures** section for instructions on submitting an appeal.

For all other requests to extend the period of time or number of treatments for a prescribed course of treatment, contact Member Services.

Coordination of Benefits (COB)

Coordination of *benefits* applies when a person has healthcare coverage under more than one Plan as defined below.

The order of benefit determination rules govern the order in which each Plan pays a claim for benefits.

- The Plan that pays first is the "Primary Plan." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the "Secondary Plan." The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 % of the total Allowable Expense.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section, the following definitions apply to COB:

Plan: Plan means This Coverage and/or Other Plan.

Other Plan: Other Plan means any individual coverage or group arrangement providing healthcare benefits or services through any of the following:

- Individual, group, blanket, or franchise insurance coverage — except that it shall not mean any blanket student accident coverage or hospital indemnity plan of $100 or less.
- Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage.
- Coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- Coverage under any tax-supported or any government program to the extent permitted by law.

Other Plan shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

This Coverage: This Coverage means, in a COB provision, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from This Coverage. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when you have healthcare coverage under more than one Plan.

Primary Plan: The Plan that typically determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that typically determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable Expense deemed customary and reasonable by us.

Covered Service: A service or supply specified in This Coverage for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage. Examples of such provisions are those related to second surgical opinions and *preauthorization* of admissions or services.

We will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This Coverage.

The payment of *benefits* under This Coverage shall be affected by the benefits that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering the *member*. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the *member* is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an Allowable Expense.

Examples of expenses that are not Allowable Expenses include, but are not limited to the following:

- The difference between the cost of a semi-private *hospital* room and a private *hospital* room, unless one of the Plans provides coverage for private *hospital* room expenses.
- Any amount in excess of the highest reimbursement amount for a specific benefit when two or more Plans that calculate benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the *member*.
- Any amount in excess of the highest of the negotiated fees when two or more Plans that provide benefits or services on the basis of negotiated fees cover the *member*.
- If the *member* is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the *provider* has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, *preauthorization*, and preferred provider arrangements.

Closed Panel: Closed panel plan is a Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other *providers*, except in cases of emergency or referral by a panel member. An HMO is an example of a closed panel plan.

Custodial Parent: Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Dependent: A dependent means, for any Other Plan, any person who qualifies as a dependent under that plan.

Order of Benefit Determination Rules

When a *member* is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. A Plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of benefits provision is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of *benefits* using the first of the following rules that apply:

a. Nondependent or Dependent.

The Plan that covers the *member* as an employee, policyholder, subscriber or retiree is the Primary Plan. The Plan that covers the *member* as a Dependent is the Secondary Plan.

For information regarding coordination of benefits with *Medicare*, please refer to the **Coordination of Benefits with Medicare** section.

b. Child Covered Under More Than One Plan.

Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of benefits is determined as follows:

(i) For a child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
- If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

(ii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the child's healthcare expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the child's healthcare expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or

- If there is no court decree allocating responsibility for the child's healthcare expenses or coverage, the order of benefits for the child is as follows:

  ◊ The Plan covering the Custodial Parent;

  ◊ The Plan covering the spouse of the Custodial Parent;

  ◊ The Plan covering the noncustodial parent; and then

  ◊ The Plan covering the spouse of the noncustodial parent.

(iii) For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non Dependent or Dependent "rule can determine the order of benefits.

d. *COBRA* or State Continuation Coverage.

If a *member* whose coverage is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non Dependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other healthcare coverage. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

If you are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non panel *provider*, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under This Coverage and other Plans. We may obtain and use the facts we need to apply these rules and determine benefits payable under This Coverage and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by us may result in claims being denied.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Coverage. If it does, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. We will not pay that amount again. The term “payment made” includes providing *benefits* in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

If a *subscriber* (or subscriber’s spouse), age 65 or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, then *Medicare* shall be

primary for the *subscriber* or spouse. The *benefits* of the *group contract* will then be the secondary form of coverage.

If a *subscriber* (or subscriber's spouse), age 65 or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, the following rules apply:

- The *group contract* will be primary for any person age 65 or older who is an Active Employee (defined as a person with "current employment status" under applicable *Medicare* Secondary Payer Laws) or the spouse of an Active Employee of any age.
- A *member* may decline *coverage* under the *group contract* and elect *Medicare* as the primary form of coverage. If the *member* elects *Medicare* as the primary form of coverage, the *group contract*, by law, cannot pay *benefits* secondary to *Medicare* for *Medicare*-covered *members*. However, the *member* will continue to be covered by the *group contract* as primary unless: (a) the *member*, or the *contract holder* on behalf of the *member*, notifies us, in writing, that the *member* does not want *benefits* under the *group contract*; or (b) the *member* otherwise ceases to be eligible for *coverage* under the *group contract*.

Disability

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with fewer than 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability, then *Medicare* shall be primary for the *member*; and the *group contract* will be the secondary form of *coverage*.

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with at least 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability — (other than End Stage Renal Disease as discussed below) the *group contract* will be primary for the *member*, and *Medicare* will be the secondary form of coverage.

End Stage Renal Disease (ESRD)

The *group contract* will remain primary for the first 30 months of a *member's* eligibility or entitlement to *Medicare* due to ESRD, 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.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to *providers* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made in Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the *benefits* under coverage.

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract.*
- Resulting from the application of any utilization review.
- Not provided because it is determined to be *investigational* or not *medically necessary*.

If you disagree with an adverse benefit determination with respect to *benefits* available under this *coverage* 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 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 you disagree with *an* adverse benefit determination, you may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, you may appoint a representative to act on your behalf as more fully discussed below. The appeal should include the reason(s) you disagree with the adverse benefit determination. The appeal must be received by us within 180 days after you received notice of the adverse benefit determination. Your appeal must be sent to:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

You may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, we will provide you with a full and fair internal review. We will provide you, free of charge, (1) with any new or additional evidence considered or relied upon, or generated in connection with the claim as well as (2) any new or additional rationale which may be the basis of a final internal adverse appeal determination as soon as possible and prior to issuing a decision on the appeal in order for you to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, we will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination. You may contact us at **800.962.2242** (TTY: **711**) to receive information on the internal review process and to receive

additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al* ***800.962.2242****.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

External Appeal Process

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on the our requirements for *medical necessity*, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission).

In order to request an external appeal pertaining to *medical necessity*, you must write to us at the address set forth above within four months from receipt of the Final Internal Adverse Benefit Determination. We will forward the appeal along with all materials and documentation to an IRO. You will be able to submit additional information to the IRO for consideration in the external appeal.

The IRO must notify you of its decision on the appeal in writing within 45 days from receipt of the request for external review.

*Member*s of a group health plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) may have a right to bring a civil action under Section 502(a) of ERISA.

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit determinations involving "urgent care decisions".

Expedited Internal Appeal Process for Claims Involving Urgent Care. You may seek expedited internal review of the determination of a claim involving urgent care by contacting us at the telephone number above. We will respond with a determination within 72 hours. You may also request an expedited external appeal simultaneously with the request for an expedited internal appeal. If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

Expedited External Appeal Process for Claims Involving Urgent Care. You may request an expedited external review of the Final Internal Adverse Benefit Determination involving an urgent care claim as defined above or where the decision concerns an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility. To request an expedited external appeal review of such a Final Internal Adverse Benefit Determination, you or your physician must contact us at the telephone number above and may provide a physician's certification indicating your claim is urgent in accordance with the definition above. Upon receipt of a request for an expedited external review, we will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a determination within 72 hours of receipt of the request.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit

Determination involving an urgent care claim as defined above and a concurrent care situation as defined below.

How to Appeal a Concurrent Care Claim Determination

Special rules apply to adverse benefit determinations involving "concurrent care decisions".

If we approved an ongoing course of treatment to be provided over a period of time or number of treatments, you have the right to an expedited appeal of any reduction or termination of that course of treatment by us before the end of such previously approved period of time or number of treatments. We will notify you of our decision to reduce or terminate your course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain an appeal decision before your *benefits* are reduced or terminated.

If you wish to appeal you must call Member Services at **800.962.2242** (TTY: **711**). We will notify you of the outcome of the appeal via telephone or facsimile not later than 72 hours after we receive the appeal. We will defer any reduction or termination of your ongoing course of treatment until a decision is reached on the appeal.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit Determination involving an urgent care claim as defined above and a concurrent care situation.

Designating an Individual to Act on Your Behalf

You may designate another individual to act on your behalf in pursuing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as your "authorized representative" or "designee" you must complete, sign, date, and return *Capital's* Member Authorization Form. You may request this form from our Member Services department at **800.962.2242** (TTY: **711**).

We communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

For purposes of reviewing *member* appeals, if *benefits* are provided under:

- An insured arrangement, we are the named fiduciary.
- A self-funded or "self-insured" arrangement, either the *plan sponsor* of the self-funded group health plan or we may serve as the named fiduciary.

The named fiduciary, with respect to any specific appeal, has full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any *member* is entitled to receive *benefits* under the terms of the group health plan. Any construction of terms of any plan document and any determination of fact adopted by the named fiduciary will be final and legally binding on all parties, subject to review only if such construction or determination is arbitrary, or capricious, or otherwise an abuse of discretion.

GENERAL PROVISIONS

Additional Services

From time to time, we, in conjunction with contracted companies, may offer other programs under this *coverage* to assist *members* in obtaining appropriate care and services.

Discounts and Incentives

We may also make available to our *members* access to health and wellness related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

These discount and incentive programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by us separately or independently from the *group contract*. There is no additional charge to *members* for accessing these discount and incentive programs. Contact the Plan Administrator for information on these programs.

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *Capital coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between *Capital* and *contract holder* without the consent or concurrence of the *members*. By electing *Capital* or accepting *Capital benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees with regard to *coverages* under this *contract*. Changes in *coverage* for *benefits* or changes in taxes or fees may result in upward adjustments in cost of *coverage* to reflect such changes. Such adjustments may occur on the earlier of either the *group contract* renewal date or the date such changes are required by law.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *cost-sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in coverage for *benefits.*

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in medical policy, *preauthorization* requirements, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

In the future, should terms and conditions associated with this coverage change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Conformity with Statutes

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or nonuse of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular healthcare *provider*. If the *member's in-network provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Preferred Provider Organization ("PPO") program that is administered by *Capital* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. If there is a conflict of terms between the *policy/contract* and the *Benefits Booklet*, the terms of the *policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

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 *Benefits Booklet*, shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Member ID Cards

Capital provides *member ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member ID card* must be presented when service is requested.

Member ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *member ID cards* must be returned to us within 31 days of the end of a *member's* coverage. *Member ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Proof of Loss

Claims for proof of loss must be submitted within 12 months after completion of the covered services to receive benefits from *Capital*. *Capital* will not be liable under this *group contract* unless proper and prompt notice is furnished to *Capital* that covered services have been rendered to a *member*. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the **Schedule of Cost Sharing** section. 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 and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to *Capital* within the time specified will not reduce any benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will *Capital* be required to accept the proof of loss more than 12 months after benefits are provided, except if the person lacks legal capacity.

Time of Payment of Claims

Claim payment for *benefits* payable under this agreement will be processed immediately upon receipt of proper proof of loss.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost-sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Payment Recoupment

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* that should not have been paid by *Capital.*

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain the physician-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Capital* and healthcare *providers* (including PCPs and other *physicians*) is an independent contractor relationship. Healthcare *providers* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital*, and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital 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 an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Public Health Emergency

In the event that *Capital* reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, *Capital* may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, *member* cost share, provisions related to the use of an *in-network provider*, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination and Autopsy

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

ADDITIONAL INFORMATION

You may submit a written request for any of the following written information:

- A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Capital*.
- The procedures adopted by *Capital* to protect the confidentiality of medical records and other *member* information.
- A description of the credentialing process for *in-network providers*.
- A list of the *in-network providers* affiliated with in-network *hospitals*.
- If *prescription drugs* are provided as a *benefit* under this *coverage,* whether a specifically identified drug is included or excluded from this *coverage*.
- A description of the process by which an *in-network provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Capital* drug *formulary* for *prescription drugs* or biologicals when the *formulary's* equivalent has been ineffective in the treatment of the *member's* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member's* case, if *prescription drugs* are provided as a *benefit* under the *member's coverage*.
- A description of the procedures followed by *Capital* to make decisions about the nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by *Capital* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network provider*.
- A 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

You may also fax your requests to **717.541.6915** or by accessing CapitalBlueCross.com, or an email can be sent to Member Services.

You may inform us of your dissatisfaction with the quality of care or service you may have received by writing to the address above or by faxing us at the number above. You can also call Member Services to register the dissatisfaction (please refer to the **How to Contact Us** section for contact information).

Capital BLUE

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 HEALTHCARE*		
For Routine History and Physical Examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer chemoprevention • Contraceptive methods/counseling[1] • Folic Acid (childbearing age)	• Hormone Replacement Therapy (HRT) – risk vs. benefits • Urinary Incontinence Assessment	At least annually
Men and Women		
• Aspirin prophylaxis (high risk) • Calcium/vitamin D intake • Drug use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity/Exercise • Seat Belt use • Statin Medication (high risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) test	Testing every 2 years for women age 19-64 at increased risk for Osteoporosis. Once every 2 years for women over age 65 and older.
BRCA screening/genetic counseling/testing	For women at risk, including those not previously diagnosed with BRCA-related cancer but who have a personal or family history of cancer.
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 healthcare provider. Suggested testing is every 1-3 years.
Domestic/Interpersonal/Partner Violence screening/counseling	At least annually for women age 19 and older; provide or refer services as determined by your healthcare provider.
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 use 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 healthcare 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 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 age 18-79. 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: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
Obesity/Overweight + Cardiovascular Risk Factor combination	Age 19 and older for high risk adults: 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**	
Haemophilus Influenza type b (Hib)	Age 19 and older Based on individual risk or healthcare provider recommendation: one or three doses
Hepatitis A (HepA)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Hepatitis B (HepB)	Age 19 and older Based on individual risk or healthcare provider recommendation: two or three doses
Human Papillomavirus (9vHPV)	Age 19-26: Two or three doses, depending on age at series initiation.
Influenza	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 healthcare provider recommendation, one or two doses.
Meningococcal (conjugate) (MenACWY)	Age 19 and older Based on individual risk or healthcare 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 healthcare provider recommendation: Two or three doses depending on indication, then booster every 2-3 years if risk remain
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose (high risk; 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) Age 65 and older. Based on individual risk or healthcare provider recommendation: One dose at least 5 years after PPSV23
Tetanus/diphtheria/pertussis (Td or Tdap)	Age 19 and older One dose of Tdap, then Td or Tdap 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 located on the Capital BlueCross web site at capbluecross.com.

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)
- Depression screening (prenatal/ postpartum)
- 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 screening
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Asymptomatic Urine Bacteria Screening
- Other preventive services may be available as determined by your healthcare provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and 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 HEALTHCARE

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years [annually].

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (thru 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (thru 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, use/education
  - 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 use screening/ counseling																				✔	✔
Anemia screening			✔	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	At least annually for adolescents of childbearing age, 11 years of age and older; provide or refer services as determined by your healthcare provider.																				
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 7 and 9																				
Hearing test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
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 or younger for at risk: at every well-child visit. Confirm HBP outside office by Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV screening/risk assessment	Annually beginning at 11 years																				
HIV test	Routine one-time testing between 15-18 years old. If indicated by high risk assessment testing may begin earlier Periodic repeat testing (at least annually) of all high risk children.																				
Lead screening test/risk assessment	Screening Test: 12 to 24 months (at risk)[2]; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid screening/risk assessment				✔		✔		✔		✔				✔	✔	✔	✔	✔	✔		
Lipid test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal depression screening	By 1 month, 2 month, 4 month and 6 months																				
Newborn bilirubin screening	✔																				
Newborn blood screen *(as mandated by the PA Department of Health)*	✔																				
Newborn critical congenital heart defect screening	✔																				
	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
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
Haemophilus influenza type b (Hib)	2 months, 4 months, 6 months (4 dose), 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk, as indicated
Hepatitis A (HepA)	12–23 months (2 doses) (catch-up through age 18)
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Human papillomavirus HPV	11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for those 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 12)
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)	16–18 years for individuals not at high risk; 10–18 years for those 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) for those at high risk.
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)
Rotavirus (RV)	2 months, 4 months, 6 months (3 doses) 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] Refer to the most recent Formulary located 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 an in-network provider (including a BlueCard facility participating provider providing inpatient services), the in-network provider will be responsible for obtaining the preauthorization. If members use an out-of-network provider or a BlueCard participating provider providing non-inpatient services, the out-of-network 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 our Utilization Management Department toll-free at 1-800-730-7219 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. In-network providers and members have full access to our medical policies and may request preauthorization for experimental or investigational services/items if there are unique member circumstances.

We only pay for services and items that are considered medically necessary. Providers and members can reference our medical policies for questions regarding medical necessity. Final determination of coverage is subject to the member's benefits and eligibility on the date of service.

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.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* 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*.

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. Capital may from time to time remove preauthorization requirements for benefits under certain dollar thresholds. For a listing of services currently requiring *preauthorization*, including any threshold requirements members and providers may consult CapitalBlueCross.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 use disorder)	*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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	
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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.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 CapitalBlueCross.com
Select Cardiac Services		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at CapitalBlueCross.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 *non participating 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*.

Applicable Group Numbers

PPO Plan 31

July, 2021

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Colonial Intermediate Unit #20	00521915

Appendix E - SUPPORT

Colonial Intermediate Unit 20

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:

Colonial Intermediate Unit 20 Employee Benefit Plan

6 Danforth Drive

Easton, PA 18045

Table of Contents

Introduction

This document is a description of the Colonial Intermediate Unit 20 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 Colonial Intermediate Unit 20 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 31-day supply)

Generic	$25 copayment
Formulary – Brand (Preferred)	$50 copayment
Non-Formulary – Brand (Non-preferred)	$100 copayment

Mail Order (up to a 90-day supply)

Generic	$45 copayment
Formulary – Brand (Preferred)	$90 copayment
Non-Formulary – Brand (Non-preferred)	$180 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 2021, your maximum cost when using ***participating*** pharmacies is $4,275 per member and $8,550 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 31 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 31-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 regardless of if your physician indicates "Dispense As Written". A member can appeal this payment based on medical necessity per the process outlined starting on page 9.

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	
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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

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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:

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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)
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*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.

Appendix F – PROFESSIONAL & ADMIN

Colonial Intermediate Unit 20

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:

Colonial Intermediate Unit 20 Employee Benefit Plan

6 Danforth Drive

Easton, PA 18045

Table of Contents

Introduction

This document is a description of the Colonial Intermediate Unit 20 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 Colonial Intermediate Unit 20 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 31-day supply)

Generic	$25 copayment
Formulary – Brand (Preferred)	$50 copayment
Non-Formulary – Brand (Non-preferred)	$100 copayment

Mail Order (up to a 90-day supply)

Generic	$45 copayment
Formulary – Brand (Preferred)	$90 copayment
Non-Formulary – Brand (Non-preferred)	$180 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 2021, your maximum cost when using ***participating*** pharmacies is $4,275 per member and $8,550 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 31 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 31-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 regardless of if your physician indicates "Dispense As Written". A member can appeal this payment based on medical necessity per the process outlined starting on page 9.

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:

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*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

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*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.

Appendix G - TRANSPORTATION

Colonial Intermediate Unit 20

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:

Colonial Intermediate Unit 20 Employee Benefit Plan

6 Danforth Drive

Easton, PA 18045

Table of Contents

Introduction

This document is a description of the Colonial Intermediate Unit 20 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 Colonial Intermediate Unit 20 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 31-day supply)

Generic	$15 copayment
Formulary – Brand (Preferred)	$30 copayment
Non-Formulary – Brand (Non-preferred)	$40 copayment

Mail Order (up to a 90-day supply)

Generic	$30 copayment
Formulary – Brand (Preferred)	$60 copayment
Non-Formulary – Brand (Non-preferred)	$80 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 2021, your maximum cost when using ***participating*** pharmacies is $4,275 per member and $8,550 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 31 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 31-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 regardless of if your physician indicates "Dispense As Written". A member can appeal this payment based on medical necessity per the process outlined starting on page 9.

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)
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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.

APPENDIX H

Colonial Intermediate Unit 20

Dental Benefits

In addition to the following Summary of Coverage provided by United Concordia Dental, the following items are incorporated by reference into this Dental Plan:

1. Member Enrollment and Eligibility, HIPPA Notice of Privacy Practices, COBRA Continuation, and Claims and Appeals Process as set forth in the Plan Document that this Appendix is attached to.

2. The Claims and Appeals Process outline starting on page 11 as "Medical Appeal Procedures" is applicable to the Dental benefits.

UNITED CONCORDIA® DENTAL

Summary of Dental Coverage

Plan Name: Colonial IU 20
Print Date: April 10, 2017

Schedule of Benefits

Concordia Flex sm

Group Name: Colonial IU 20
Group Number: 902213000, 902213001, 902213002, 902213003, 902213004, 902213005, 902213006, 902213007, 902213008, 902213009, 902213010, 902213011, 902213012, 902213013, 902213014, 902213015, 902213016, 902213017

Effective Date: July 1, 2017

	Plan Pays
Class I Services	
• *Exams*	***100%***
• *All X-Rays*	***100%***
• *Cleanings & Fluoride Treatments*	***100%***
• *Sealants*	***100%***
• *Palliative Treatment (Emergency)*	***100%***
• *Space Maintainers*	***100%***
Class II Services	
• *Basic Restorative (Fillings, etc.)*	***100%***
• *Endodontics*	***100%***
• *Non-surgical Periodontics*	***100%***
• *Repairs of Crowns, Inlays, Onlays*	***100%***
• *Repairs of Bridges*	***100%***
• *Denture Repair*	***100%***
• *Simple Extractions*	***100%***
• *Surgical Periodontics*	***100%***
• *Complex Oral Surgery*	***100%***
• *General Anesthesia and/or Nitrous Oxide and/or IV Sedation*	***100%***
Class III Services	
• *Inlays, Onlays, Crowns*	***100%***
• *Prosthetics (Bridges, Dentures)*	***100%***
Orthodontics	
• *Diagnostic, Active, Retention Treatment*	***80%***
• *Limited to Dependent children under the age of 19*	

Summary of Coverage

Deductibles & Maximums

- *$0 Program Dollar Deductible*
- *$1500 per Calendar Year Maximum per Member*
- *$2500 Lifetime Maximum per Member for Orthodontics*

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

Contact United Concordia

Phone 1-866-851-7564 *Customer service representatives are available from 8 a.m. - 6 p.m. ET. Assistance can also be received outside normal customer service hours through our Interactive Voice Recognition (IVR) system. Use the system 24/7 to access claim status, benefits and coverage information in 150 languages.*

Web ***www.UnitedConcordia.com***
Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

   For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).

22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.

28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 36 month(s).
2. Bitewing x-rays – one (1) set(s) per 6 months.
3. Oral Evaluations:
    - Comprehensive and periodic – one (1) of these services per 6 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations – one (1) of these services per dentist per patient per 12 months
    - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis – one (1) per 6 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – one (1) per 6 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age nineteen (19) on permanent first and second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fourteen (14).
9. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays – not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
10. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
11. Pulpal therapy – one (1) per primary tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six (6) and primary posterior molars under age twelve (12).
12. Root canal retreatment – one (1) per tooth per lifetime.
13. Recementation – one (1) per 12 months Recementation during the first 12 following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
14. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
15. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.

    This limitation does not apply to Group Policies issued and delivered in Maryland.

16. Intraoral films:
    - Occlusal – two (2) per 24 months under age eight (8).

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Summary of Coverage

Choice of Dentist

You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a United Concordia participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles or amounts exceeding the program maximum.

Participating dentists will also complete and send claims directly to United Concordia. If you go to a dentist who is not a United Concordia participating dentist, you may have to pay the dentist at the time of service. You will also have to pay the difference between the dentist's charge and the amount that the Plan allows, in addition to any coinsurance or deductible. You may have to submit the claim and wait for United Concordia to reimburse you.

To find a participating dentist, visit Find a Dentist on United Concordia's website at www.UnitedConcordia.com or telephone United Concordia's Interactive Voice Response System at 1-866-851-7564.

When you visit the dental office, let your dentist know that you are covered under a United Concordia dental program. If your dentist has questions about your eligibility or benefits, instruct the office to call United Concordia's Interactive Voice Response System at 1-866-851-7564 or visit Dental Inquiry at www.UnitedConcordia.com/dental-insurance/dentist.

Claims Submission and Payment

Upon completion of treatment, a claim form needs to be filed with United Concordia. If you visit a United Concordia participating dentist, the dental office will submit claims forms for you and your dependents. United Concordia will pay covered benefits directly to the participating dentist. Both you and the dentist will receive an explanation of benefits.

Most dental offices submit claim forms for patients. However, if you do not receive treatment from a participating dentist, you may have to complete and send a claim form to United Concordia in the event the dental office will not do this for you. Send the claim form to the address on the claim form.

Coordination of Benefits

If you or your dependents are covered by any other dental benefits plan and receive a service covered by this Plan and the other, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits.

The other plan will be secondary and determine its benefits after the other plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

Changes to the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason. All changes will be communicated in writing. If the Plan is discontinued, benefits, if any, will be paid for all charges incurred for covered services prior to the termination date.

Predetermination

A predetermination confirms services you are about to receive are covered under your dental plan. It helps you estimate any out-of-pocket expenses you may incur by calculating the total amount you owe and what your plan will cover based on your coinsurance amounts. It also notifies you of alternate treatment options covered by your dental plan. We encourage you to ask your dentist to submit a pre-determination to United Concordia for any procedure that exceeds $500. A predetermination is not a guarantee of payment—it is only an estimate of what you can expect to owe.

My Dental Benefits and Online Tools

Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more at www.UnitedConcordia.com. Additionally, you can Find a Dentist, access valuable member resources and download member apps from the website.

APPENDIX I - SUPPORT

Colonial Intermediate Unit 20

Capital BlueCross Vision Benefits

In addition to the following Certificate of Coverage provided by Capital BlueCross, the following items are incorporated by reference into this Vision Plan:

Please consult the Appeal Process contained in the Plan Document which shall control the appeal procedure. The information contained in Appendix I 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

00521915

BlueCross VisionSM

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 Member Services 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).

ફ્રભાષીયા 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).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែភ្នាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ 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

WELCOME

Thank you for choosing *vision coverage* from the Capital BlueCross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of Coverage") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under the group health plan. It also define terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this coverage. We have also included our contact information so you can reach us when you have questions or concerns. There are five sections in this *Benefits Booklet* that we would like to call out to help you to better understand your *coverage.* You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Benefits**, provides a summary of your *benefits* and any *benefit* limitations under your plan.
3. **Schedule of Limitations**, contains a list of the services with *coverage* limitations.
4. **Exclusions**, lists the services not covered under your plan.
5. **Claims Reimbursement**, offers important information on how to file a claim for *benefits*.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the subscriber. We may also say "you" or "your" to mean the member, which is anyone covered under your plan **("dependents").**
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your coverage, we encourage you to call Member Services. You will find their number on the back of your *member identification (ID) card*.

IMPORTANT NOTICES

There are a few important points that you need to know about your vision *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your vision expenses. You should read this *Benefits Booklet* carefully to determine which vision services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your vision care, use *in-network providers.* We base our *coverage* determinations on whether a vision service is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying coverage. And we don't provide them financial incentives to encourage you to use fewer covered services. We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet, Certificates of Coverage,* or Certificates of Insurance that we may have issued to you previously under your coverage with us.
- This *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 *benefits under* this *Benefits Booklet* do not include the e*ssential benefi*ts for pediatric (under the age of *19) visi*on services *under PPACA;* such benefits must be embedded in a Qualified Health Plan, or *QHP*, for medical benefits, as defined in *PPACA.*

HOW TO CONTACT US

We are committed to providing excellent ser*vice to* you. We offer you a variety of ways to connect with us to answer your questions, confirm your benefits and coverage, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your *benefits*, claims, and cost-share balances. You can locate *in-network provider*s; change personal information; or view, print, or request *member ID cards*.

Member Services

Member Services representatives can answer your questions, confirm your benefits and coverage, and help you find *in-network providers*. Member Services can also help answer your questions about how to access providers who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	1-800-905-4102 or TTY users, 711 during normal business hours
Email	Complete the Contact Us form at CapitalBlueCross.com.
Write	BlueCross *Vision* c/o National Vision Administrators P.O. Box 2187 Clifton, NJ 07015
FAX	1-973-574-2430
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a health and wellness center	Go to CapitalBlueStore.com or call 855.505.BLUE (2583) to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. The Promenade Shops at Saucon Valley 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 Hampden Marketplace 4500 Marketplace Way Enola, PA 17025

DEFINITIONS

The terms below have the following meanings whenever italicized in your Benefits Booklet or the *group contract*:

Allowance Amount: The payment level that we reimburse for *benefits* provided to you under your *coverage*.

Annual Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or *members* to make enrollment changes.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply or upon completion of the procedure. The *benefit period* does not include any part of a calendar year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect.

Benefit Period Program 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 procedures or dollars. *Benefit period* program maximums are described in the **Summary of Benefits** section of this *Benefits Booklet*.

Benefits: Those vision services and supplies covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to subscribers as part of the group contract entered into by the contract holder and us. It explains the terms of this coverage, including the benefits available to members and information on how this coverage is administered.

Capital: Capital BlueCross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the coverage for *benefits* to *members*. The contract holder is identified in the *group policy*.

Copayment: The fixed dollar amount that you must pay for certain *benefits*. You must pay copayments directly to the *provider* at the time of service. Copayments, if any, are identified in the **Summary of Benefits** section of this *Benefits Booklet* or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

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 us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date the *member's coverage* under the *group contract* begins as shown on our records.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group 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 *Benefits Booklet*, between the *contract holder* and us for the administration of *benefits*.

Group Effective Date: The date that is specified in the *group policy/contract* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons who have not previously enrolled with us may do so; or those who have previously enrolled in a *Capital* program may switch to another program.

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.

In-network Provider: An *Ophthalmologist, Optometrist,* or *Optician* who is properly licensed, and has a contract with *Capital* or its designee to provide *benefits* under this *coverage*.

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, and for a period of up to six months thereafter, unless otherwise provided in our applicable medical policies;
- It is the subject of a current Investigational new drug or new device application on file with the FDA;
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives;
- It is not investigational in itself, but would not be medically necessary except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records;
- The protocol(s) pursuant to which the treatment or procedure is to be delivered;
- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure;

- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- Regulations and other official actions and publications issued by the federal government; and
- The opinion of a third party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Level of Coverage: The level of payment made by us to an *in-network provider* or an *out-of-network provider* described in the **Summary of Cost-Sharing and Benefits** section of this *Benefits Booklet*.

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 the purpose of this definition, "generally accepted standards of good medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national *physician* specialty society recommendations and the views of *physicians* practicing in relevant clinical areas and any other clinically relevant factors. The fact that a *provider* may prescribe, recommend, order, or approve a service or supply does not make it *medical necessity* or a covered *benefit*.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under *COBRA*) who enrolled for *coverage* and 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. The term member is sometimes identified with the pronouns "you" and "your" in this Benefits Booklet.

Member Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract.*

Ophthalmologist: A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.

Optically Necessary/Optical Necessity: A prescription or a change of prescription is required to correct visual function.

Optician: A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an *Optometrist* or an *Ophthalmologist*.

Optometrist: A person licensed to practice Optometry as defined by the laws of the state in which his or her services are rendered.

Out-of-network Provider: A provider who is not under contract with us or a *provider* who is not an *in-network provider.*

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulation, each as amended.

Provider: A person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

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.

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.

Services: Treatment performed by an *Ophthalmologist, Optometrist,* or *Optician* or under his/her supervision and direction and when necessary, customary and reasonable, as determined by *Capital*, using standards of generally accepted vision practice.

Standard Lenses: Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Treatment: Caring for or dealing with a vision condition.

Vision Examination: An examination of principal vision functions. A *vision examination* includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the *provider* practice is located.

HOW TO ACCESS BENEFITS

Member Identification Card (ID Card)

Your *member ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your *member ID card* and any other ID cards for other vision coverage **each time you seek vision services**. *Providers* use the information from your *member ID card* to submit *claims* for processing and payment.

Important Information about Your *Member ID card*:

- The words "BlueCross *Vision*" on the front of the card inform *providers* that you have vision coverage with us.
- On the back of the *member ID card*, you will find the BlueCross *Vision* telephone number.

Obtaining Benefits for Vision Services

We classify providers as either "in network" or "out of network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The provider you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an in-network provider.

Stay current about your providers. To confirm your providers are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your member ID card.

Depending on your specific *coverage*, the *benefits* provided and the level of payment for *benefits* is affected by whether you choose an in-network *provider.*

Members can choose any licensed *Ophthalmologist*, *Optometrist*, or *Optician* for their care, although their costs are generally less when they see an in-network *provider*. You have the option to visit an *out-of-network provider*, but it generally costs you more. *Providers*, including, without limitation, *in-network providers*, are solely responsible for the vision care rendered to their patients.

NOTE: Remember, *members* have the greatest savings when they choose an in-network *provider*.

Services Provided By In-Network Providers

You can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

***In-network providers* may seek payment for the member portion of the costs for services and/or supplies that qualify as *benefits*.** An in-network *provider* may seek payment from you for noncovered services, including specifically excluded services (e.g., *cosmetic procedures*, investigational procedures, etc.), or services in excess of *benefit period maximums*. The *in-network provider* must inform you prior to performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability.

The status of an *Ophthalmologist*, *Optometrist*, or *Optician* as an in-network *provider* may change from time to time. It is your responsibility to verify the current status of a *provider*. To find an in-network provider, *members* can visit capbluecross.com or call 1-800-905-4102.

Services Provided By Out-of-Network Providers

Services provided by *out-of-network providers* may require higher *member* portion of costs or may not be covered *benefits*. If such services are covered, *benefits* will be reimbursed at the *allowance amount* applicable to this *coverage*. Information on whether *benefits* are provided when performed by an out-of-network *provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Benefits**.

Out-of-Country Services

When you are traveling outside the United States and need vision care, go to the nearest appropriate treatment facility. When you receive out-of-country services, you must pay for treatment at the time of service and get a detailed receipt from the treating provider. In addition to providing the *provider's* name and address (including country), the receipt should describe the *vision* services performed by the *provider*. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of *your* vision coverage, and is based on the out-of-network *benefit* provided through the *group contract*.

SUMMARY OF BENEFITS

The following table provides a summary of the *benefits* provided under this *coverage*.

The *benefits* listed in this section are covered when provided by a properly licensed *Ophthalmologist*, *Optician* or *Optometrist* within the standards of generally accepted vision practice.

It is important for you to remember that this *coverage* is subject to the exclusions and limitations as described in this *Benefits Booklet*. Please see the **Schedule of Limitations,** and **Schedule of Exclusions** sections for specific *benefit* limitations and/or exclusions provided under this *coverage*.

SUMMARY OF BENEFITS **You will be responsible for paying the *deductible*, *copayments* and *coinsurance* percentage reflected in this chart. Unless otherwise stated, services that apply a *copayment* do not require that the *deductible* be satisfied first. *Out-of-network providers* may balance bill you, which would be additional costs to you over and above any *deductible*, *copayments* and *coinsurance*.**		
Benefit frequencies are based on the date of service.	**Amounts You Are Responsible For:**	
	In-Network Providers	***Out-of-Network Providers***
EXAMINATION		
	\$200 per employee per fiscal year (7/1 through 6/30) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
FRAMES		
Benefit frequency once every twenty-four months**	\$200 per employee per fiscal year (7/1 through 6/30) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
EYEGLASS LENSES (PER PAIR)		
• Single Vision *Standard Lenses* • Bifocal *Standard Lenses* • Trifocal *Standard Lenses* • Aphakic/Lenticular *Standard Lenses* **LASIK SURGERY**	\$200 per employee per fiscal year (7/1 through 6/30) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
CONTACT LENSES		
CONTACT LENSES* *(in lieu of frames and eyeglass lenses)* • Cosmetic • Medically necessary (hard lenses) • Medically necessary (soft lenses)	\$200 per employee per fiscal year (7/1 through 6/30) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
LASIK SURGERY	Not covered	

*Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.

*Frame allowance at Walmart® Vision Centers & Sam's Club is 50% of the frame allowance shown above with no additional retail discount.

**Contact lens allowance at Walmart® Vision Centers & Sam's Club is 75% of the contact lens allowance shown above with no additional retail discount.

Discounted amounts may vary and may not be honored at all *In-network provider* locations.

VALUE ADDED DISCOUNTS – LENS OPTIONS:

In addition to the standard *benefits* program, Value Added Vision discounts may be available when services are rendered by in-network providers. The discounted pricing is not considered insured benefits under this contract. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We do not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart or Sam's Club. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Lens Options purchased from a *in-network provider* will be provided to you at the amounts listed below. Lens Options not listed may be discounted 20% of the retail charge. Lens Options that are purchased from an out-of-network *provider* will not be discounted and are your full responsibility.

Contact your group leader for a list of discounted services.

VALUE ADDED PLUS

After you have exhausted your funded *benefits* you are eligible to access discounts on additional purchases during the *benefit period* through the Value Added Plus option. Discounts through the Value Added Plus option may be available when services are rendered by in-network providers. The discounted pricing is not considered insured *benefits* under this coverage. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We dos not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart, Sam's Club and Contact Fill. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Contact your group leader for a list of discounted services.

SCHEDULE OF LIMITATIONS

In addition to the exclusions listed in the *Schedule of Exclusions* section, the *benefits* provided under your vision *coverage* have the following limitations:

1. If the contact lenses *benefit* is payable in lieu of the standard eyeglass lenses *benefit* and the eyeglass frame *benefit*, the *member* shall be eligible to receive *benefits* under the standard eyeglass lenses *benefit* or the eyeglass frame *benefit* only after the contact lenses *benefit* frequency has ended.

2. Payment will be made for either eyeglass lenses or contact lenses within a *benefit period*. Payment will not be made for both.

3. *In-network providers* are not contractually obligated to offer sale prices in addition to the out lined *coverage*.

4. Regardless of *optical necessity*, vision *benefits* are not available more frequently than specified in the **Summary of Benefits** section.

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Benefits Booklet*, we will not provide *benefits* under this *coverage* for the following services, supplies or charges;

1. Services or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury;
3. Charges for which benefits or services are provided to you by any hospital, medical or vision service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
4. Services provided or supplies furnished or devices started prior to your effective date of *coverage*;
5. Treatment or supplies which you would have no legal obligation to pay;
6. Professional services and/or materials in connection with blended bifocals, no line, or progressive addition lenses; compensated or special multi-focal lenses; plain (non-prescription) lenses; anti-reflective, scratch, UV400, or any coating of lamination applied to lenses; and tints other than solid;
7. Examinations or materials which are not listed herein as a covered service;
8. Medical attention or surgical treatment of the eye, eyes or supporting structures;
9. Drugs or any other medications;
10. Procedures determined to be special or unusual (orthoptics, vision training, tonography, etc.);
11. *Vision examinations* or materials required for employment;
12. V*ision examinations* or materials sponsored by the *subscriber's* employer without charge to the *subscriber*;
13. Duplicate and temporary devices, appliances, and services;
14. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, unless you would otherwise meet the frequency limitations;
15. Parts or repair of frames;
16. Lenses which do not require a prescription;
17. Sunglasses;
18. Two pair of glasses in lieu of bifocals;
19. Low vision aids (i.e., magnifying glasses to help people with severe sight issues);
20. Industrial safety lenses and safety frames with or without side shields;
21. Services incurred after your termination date of coverage except as provided for in this *Benefits Booklet*;

22. Services received in a country with which United States law prohibits transactions;
23. Charges that exceed the *allowance amount;*
24. Cost-sharing amounts you must pay as outlined in this Benefits Booklet;
25. Travel expenses incurred together with *benefits*;
26. Court ordered services when not of *optical necessity* and/or not a covered *benefit*;
27. 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 under law;
28. Services not billed by an eligible *provider;*
29. Vision services rendered by a *provider* who is a member of your *immediate family*;
30. Telephone and electronic consultations, including virtual services, between you and a *provider*;
31. Charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of vision records, or for your decision to cancel a vision procedure;
32. Any other service or treatment, except as provided in this *Benefits Booklet*.

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

This section explains when and why your *coverage* with us may end.

Termination of Group Contract

When the group contract ends, it automatically terminates *coverage* for all *members* in the group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of Coverage for Members

You cannot be terminated based on health status, health care need, or the use of our *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. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child - *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* 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 us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA (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 us.

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.

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 us. The claim is based upon the itemized statement of charges for vision services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which we 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 us.

In-Network providers

When you receive services and/or supplies from an *in-network provider*, you should show their *member ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* is made directly to the *in-network provider*.

Out-of-Network providers

If you visit an out-of-network *provider*, you may be required to pay for the service and/or supplies at the time it is rendered. Although some *out-of-network providers* file claims on behalf of our *members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made.

Allowance Amount

The *benefit* payment amount is based on the *allowance amount* on the date the service is rendered or on the date the expense is deemed incurred by *Capital*.

Filing A Claim

Capital does not require any special vision claim form. *In-network providers* will fill out and submit the claims. Some *out-of-network providers* may also provide this service upon request. If you receive services from an *out-of-network provider* who does not provide this service, you can submit your own claim directly to us at the mailing address listed below. A separate claim form must be completed for each *member* who received vision services. For your convenience, you can print a claim form from our website at CapitalBlueCross.com.

BlueCross *Vision*
c/o National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Members must also provide additional information, if applicable, including but not limited to, other insurance payment information. If you need help submitting a vision claim you can contact Customer Service at **1-800-905-4102**.

We will contact you and/or the *provider* if additional information is needed.

Out-of-Country Claims

When you obtains vision services outside of the United States, you must pay for the treatment at the time of service, get a detailed receipt from the treating provider, and then submit the claim to us.

In addition to providing the provider's name and address (including country), the receipt should describe the *vision* services performed by the provider. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of this vision coverage, and is based on the out-of-network benefit provided through the group contract.

Claim Filing and Processing Time Frames

Time Frames for Submitting Vision Claims

All claims must be submitted within 12 months from the date of service.

Time Frames Applicable to Vision Claims

If your claim involves a vision service or supply that was already received, we will process the claim within 30 days of receiving the claim. We may extend the 30-day time period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

The coordination of *benefits* provision 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 , 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 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 vision benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when you have 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 percent of the total Allowable Expense deemed customary and reasonable by *Capital*.

Covered Service: A service or supply specified in This Coverage for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage.

We will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This Coverage.

The payment of *benefits* under This Coverage shall be affected by the benefits that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a 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 you 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:

- 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 you.

- 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 you.

- 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 you have failed to comply with the Plan provisions.

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.

      (i) 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.

   b. Child Covered Under More Than One Plan.

      (i) 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:

      (ii) 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.

      (iii) 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.

      (iv) 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. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent "rule can determine the order of benefits.

d. *COBRA* or State Continuation Coverage.

If a *member* whose coverage is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other 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. We may obtain and use the facts it needs to apply these rules and determine benefits payable under This Coverage and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by *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, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. We will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability/Subrogation

Subrogation is the right of the *contract holder* to recover the amount it has paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in *the contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made In Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the benefits under your vision *coverage*.

To Appeal an Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract*;
- Not provided because it is determined to be *investigational* or not of *optical necessity*.

If you disagree with an adverse benefit determination with respect to *benefits* available under your coverage you may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

Your appeal must be sent to:

BlueCross *Vision*
c/o National Vision Administrators
1200 Route 46 West
Clifton, NJ 07013

You have the right to submit written comments, documents, records, and other information relating to your claim for *benefits*. You also have the right to receive, upon request and free of charge, copies of all documents, records, and other information related to your adverse benefit determination. A request for information does **not** constitute an appeal. To receive copies of this information, requests should be mailed to the above listed address.

If the notice of an adverse benefit determination advises you to submit additional information in order to perfect the claim, then you should make arrangements to submit all requested information if and when you file an appeal. Failure to promptly submit any additional information may result in the denial of your appeal.

The following time frames apply to our review of your appeal. We will notify you of our decision within:

- 60 days of receiving your appeal if the appeal involves a vision claim and you file the appeal after receiving the vision service.
- 30 days of receiving your *a*ppeal if you file an appeal prior to receiving the vision service.

If your coverage is an employer-sponsored group plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) and if you remain dissatisfied upon completion of the mandatory appeal process described above, you have the right to bring a civil action under ERISA Section 502(a).

Designating an Individual to Act On Your Behalf

You may designate another individual to act on your behalf in pursuing a *benefit* claim or appeal of an unfavorable *benefit* decision.

To designate an individual to serve as your “authorized representative”, you must complete, sign, date, and return a Member Authorization Form. You may request this form from our Member Service Department at **1-800-905-4102**.

We communicate with your authorized representative only after we receives the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

GENERAL PROVISIONS

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *this coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between us and *contract holder* without the consent or concurrence of the *members*. By electing us or accepting our *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 thirty (30) 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 thirty (30) 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 *member* portion of cost, 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 thirty (30) days prior to the effective date of any change in coverage for *benefits.*

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.

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in policy or underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

Conformity With State Statues

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 non-use of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's* enrollment to a particular *provider*. If the *member's in-network 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 *Benefits Booklet* shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Member ID Cards

Capital provides *member ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member ID card* must be presented when service is requested.

Member ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, member *ID cards* must be returned to us within 31 days of the *member's* termination. *Member ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 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 legal notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest address reflected in *Capital's* records.
- If to the *contract holder*: to the latest address electronic and/or physical provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Health care *providers* maintain direct relationship with *members* and are solely responsible to *members* for all medical and/or vision services. The relationship between *Capital* and health care *providers* 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 an in-network *provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Physical Examination

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.

Applicable Group Numbers

Vision Plan 27 Support

July 2021

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Colonial Intermediate Unit #20	00521915

APPENDIX J – PROFESSIONAL

Colonial Intermediate Unit 20

Capital BlueCross Vision Benefits

In addition to the following Certificate of Coverage provided by Capital BlueCross, the following items are incorporated by reference into this Vision Plan:

Please consult the Appeal Process contained in the Plan Document which shall control the appeal procedure. The information contained in Appendix J 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

00521915

BlueCross VisionSM

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 Member Services 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).

ફ્રભાષીયા 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).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែភ្នាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ 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

WELCOME

Thank you for choosing *vision coverage* from the Capital BlueCross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of Coverage") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under the group health plan. It also define terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this coverage. We have also included our contact information so you can reach us when you have questions or concerns. There are five sections in this *Benefits Booklet* that we would like to call out to help you to better understand your *coverage.* You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Benefits**, provides a summary of your *benefits* and any *benefit* limitations under your plan.
3. **Schedule of Limitations**, contains a list of the services with *coverage* limitations.
4. **Exclusions**, lists the services not covered under your plan.
5. **Claims Reimbursement**, offers important information on how to file a claim for *benefits*.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the subscriber. We may also say "you" or "your" to mean the member, which is anyone covered under your plan **("dependents").**
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your coverage, we encourage you to call Member Services. You will find their number on the back of your *member identification (ID) card*.

IMPORTANT NOTICES

There are a few important points that you need to know about your vision *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your vision expenses. You should read this *Benefits Booklet* carefully to determine which vision services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your vision care, use *in-network providers.* We base our *coverage* determinations on whether a vision service is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying coverage. And we don't provide them financial incentives to encourage you to use fewer covered services. We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet, Certificates of Coverage,* or Certificates of Insurance that we may have issued to you previously under your coverage with us.
- This *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 *benefits under* this *Benefits Booklet* do not include the e*ssential benefi*ts for pediatric (under the age of *19) visi*on services *under PPACA;* such benefits must be embedded in a Qualified Health Plan, or *QHP*, for medical benefits, as defined in *PPACA.*

HOW TO CONTACT US

We are committed to providing excellent ser*vice to* you. We offer you a variety of ways to connect with us to answer your questions, confirm your benefits and coverage, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your *benefits*, claims, and cost-share balances. You can locate *in-network provider*s; change personal information; or view, print, or request *member ID cards*.

Member Services

Member Services representatives can answer your questions, confirm your benefits and coverage, and help you find *in-network providers*. Member Services can also help answer your questions about how to access providers who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	1-800-905-4102 or TTY users, 711 during normal business hours
Email	Complete the Contact Us form at CapitalBlueCross.com.
Write	BlueCross *Vision* c/o National Vision Administrators P.O. Box 2187 Clifton, NJ 07015
FAX	1-973-574-2430
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a health and wellness center	Go to CapitalBlueStore.com or call 855.505.BLUE (2583) to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. The Promenade Shops at Saucon Valley 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 Hampden Marketplace 4500 Marketplace Way Enola, PA 17025

DEFINITIONS

The terms below have the following meanings whenever italicized in your Benefits Booklet or the *group contract*:

Allowance Amount: The payment level that we reimburse for *benefits* provided to you under your *coverage*.

Annual Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or *members* to make enrollment changes.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply or upon completion of the procedure. The *benefit period* does not include any part of a calendar year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect.

Benefit Period Program 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 procedures or dollars. *Benefit period* program maximums are described in the **Summary of Benefits** section of this *Benefits Booklet*.

Benefits: Those vision services and supplies covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to subscribers as part of the group contract entered into by the contract holder and us. It explains the terms of this coverage, including the benefits available to members and information on how this coverage is administered.

Capital: Capital BlueCross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the coverage for *benefits* to *members*. The contract holder is identified in the *group policy*.

Copayment: The fixed dollar amount that you must pay for certain *benefits*. You must pay copayments directly to the *provider* at the time of service. Copayments, if any, are identified in the **Summary of Benefits** section of this *Benefits Booklet* or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

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 us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date the *member's coverage* under the *group contract* begins as shown on our records.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group 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 *Benefits Booklet*, between the *contract holder* and us for the administration of *benefits*.

Group Effective Date: The date that is specified in the *group policy/contract* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons who have not previously enrolled with us may do so; or those who have previously enrolled in a *Capital* program may switch to another program.

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.

In-network Provider: An *Ophthalmologist, Optometrist,* or *Optician* who is properly licensed, and has a contract with *Capital* or its designee to provide *benefits* under this *coverage*.

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, and for a period of up to six months thereafter, unless otherwise provided in our applicable medical policies;
- It is the subject of a current Investigational new drug or new device application on file with the FDA;
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives;
- It is not investigational in itself, but would not be medically necessary except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records;
- The protocol(s) pursuant to which the treatment or procedure is to be delivered;
- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure;

- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- Regulations and other official actions and publications issued by the federal government; and
- The opinion of a third party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Level of Coverage: The level of payment made by us to an *in-network provider* or an *out-of-network provider* described in the **Summary of Cost-Sharing and Benefits** section of this *Benefits Booklet*.

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 the purpose of this definition, "generally accepted standards of good medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national *physician* specialty society recommendations and the views of *physicians* practicing in relevant clinical areas and any other clinically relevant factors. The fact that a *provider* may prescribe, recommend, order, or approve a service or supply does not make it *medical necessity* or a covered *benefit*.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under *COBRA*) who enrolled for *coverage* and 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. The term member is sometimes identified with the pronouns "you" and "your" in this Benefits Booklet.

Member Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract.*

Ophthalmologist: A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.

Optically Necessary/Optical Necessity: A prescription or a change of prescription is required to correct visual function.

Optician: A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an *Optometrist* or an *Ophthalmologist*.

Optometrist: A person licensed to practice Optometry as defined by the laws of the state in which his or her services are rendered.

Out-of-network Provider: A provider who is not under contract with us or a *provider* who is not an *in-network provider.*

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulation, each as amended.

Provider: A person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

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.

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.

Services: Treatment performed by an *Ophthalmologist, Optometrist,* or *Optician* or under his/her supervision and direction and when necessary, customary and reasonable, as determined by *Capital*, using standards of generally accepted vision practice.

Standard Lenses: Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Treatment: Caring for or dealing with a vision condition.

Vision Examination: An examination of principal vision functions. A *vision examination* includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the *provider* practice is located.

HOW TO ACCESS BENEFITS

Member Identification Card (ID Card)

Your *member ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your *member ID card* and any other ID cards for other vision coverage **each time you seek vision services**. *Providers* use the information from your *member ID card* to submit *claims* for processing and payment.

Important Information about Your *Member ID card*:

- The words "BlueCross *Vision*" on the front of the card inform *providers* that you have vision coverage with us.
- On the back of the *member ID card*, you will find the BlueCross *Vision* telephone number.

Obtaining Benefits for Vision Services

We classify providers as either "in network" or "out of network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The provider you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an in-network provider.

Stay current about your providers. To confirm your providers are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your member ID card.

Depending on your specific *coverage*, the *benefits* provided and the level of payment for *benefits* is affected by whether you choose an in-network *provider.*

Members can choose any licensed *Ophthalmologist*, *Optometrist*, or *Optician* for their care, although their costs are generally less when they see an in-network *provider*. You have the option to visit an *out-of-network provider*, but it generally costs you more. *Providers*, including, without limitation, *in-network providers*, are solely responsible for the vision care rendered to their patients.

NOTE: Remember, *members* have the greatest savings when they choose an in-network *provider*.

Services Provided By In-Network Providers

You can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

***In-network providers* may seek payment for the member portion of the costs for services and/or supplies that qualify as *benefits*.** An in-network *provider* may seek payment from you for noncovered services, including specifically excluded services (e.g., *cosmetic procedures*, investigational procedures, etc.), or services in excess of *benefit period maximums*. The *in-network provider* must inform you prior to performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability.

The status of an *Ophthalmologist*, *Optometrist*, or *Optician* as an in-network *provider* may change from time to time. It is your responsibility to verify the current status of a *provider*. To find an in-network provider, *members* can visit capbluecross.com or call 1-800-905-4102.

Services Provided By Out-of-Network Providers

Services provided by *out-of-network providers* may require higher *member* portion of costs or may not be covered *benefits*. If such services are covered, *benefits* will be reimbursed at the *allowance amount* applicable to this *coverage*. Information on whether *benefits* are provided when performed by an out-of-network *provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Benefits**.

Out-of-Country Services

When you are traveling outside the United States and need vision care, go to the nearest appropriate treatment facility. When you receive out-of-country services, you must pay for treatment at the time of service and get a detailed receipt from the treating provider. In addition to providing the *provider's* name and address (including country), the receipt should describe the *vision* services performed by the *provider*. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of *your* vision coverage, and is based on the out-of-network *benefit* provided through the *group contract*.

SUMMARY OF BENEFITS

The following table provides a summary of the *benefits* provided under this *coverage*.

The *benefits* listed in this section are covered when provided by a properly licensed *Ophthalmologist*, *Optician* or *Optometrist* within the standards of generally accepted vision practice.

It is important for you to remember that this *coverage* is subject to the exclusions and limitations as described in this *Benefits Booklet*. Please see the **Schedule of Limitations,** and **Schedule of Exclusions** sections for specific *benefit* limitations and/or exclusions provided under this *coverage*.

SUMMARY OF BENEFITS **You will be responsible for paying the *deductible*, *copayments* and *coinsurance* percentage reflected in this chart. Unless otherwise stated, services that apply a *copayment* do not require that the *deductible* be satisfied first. *Out-of-network providers* may balance bill you, which would be additional costs to you over and above any *deductible*, *copayments* and *coinsurance*.**		
Benefit frequencies are based on the date of service.	**Amounts You Are Responsible For:**	
	In-Network Providers	***Out-of-Network Providers***
EXAMINATION		
	\$200 per family per fiscal year (9/1 through 8/31) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
FRAMES		
Benefit frequency once every twenty-four months**	\$200 per family per fiscal year (9/1 through 8/31) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
EYEGLASS LENSES (PER PAIR)		
• Single Vision *Standard Lenses* • Bifocal *Standard Lenses* • Trifocal *Standard Lenses* • Aphakic/Lenticular *Standard Lenses* **LASIK SURGERY**	\$200 per family per fiscal year (9/1 through 8/31) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
CONTACT LENSES		
CONTACT LENSES* *(in lieu of frames and eyeglass lenses)* • Cosmetic • Medically necessary (hard lenses) • Medically necessary (soft lenses)	\$200 per family per fiscal year (9/1 through 8/31) Includes : Exam; Frames, Eyeglass lenses & Contact Lenses	
LASIK SURGERY	Not covered	

*Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.

*Frame allowance at Walmart® Vision Centers & Sam's Club is 50% of the frame allowance shown above with no additional retail discount.

**Contact lens allowance at Walmart® Vision Centers & Sam's Club is 75% of the contact lens allowance shown above with no additional retail discount.

Discounted amounts may vary and may not be honored at all *In-network provider* locations.

VALUE ADDED DISCOUNTS – LENS OPTIONS:

In addition to the standard *benefits* program, Value Added Vision discounts may be available when services are rendered by in-network providers. The discounted pricing is not considered insured benefits under this contract. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We do not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart or Sam's Club. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Lens Options purchased from a *in-network provider* will be provided to you at the amounts listed below. Lens Options not listed may be discounted 20% of the retail charge. Lens Options that are purchased from an out-of-network *provider* will not be discounted and are your full responsibility.

Contact your group leader for a list of discounted services.

VALUE ADDED PLUS

After you have exhausted your funded *benefits* you are eligible to access discounts on additional purchases during the *benefit period* through the Value Added Plus option. Discounts through the Value Added Plus option may be available when services are rendered by in-network providers. The discounted pricing is not considered insured *benefits* under this coverage. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We dos not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart, Sam's Club and Contact Fill. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Contact your group leader for a list of discounted services.

SCHEDULE OF LIMITATIONS

In addition to the exclusions listed in the *Schedule of Exclusions* section, the *benefits* provided under your vision *coverage* have the following limitations:

1. If the contact lenses *benefit* is payable in lieu of the standard eyeglass lenses *benefit* and the eyeglass frame *benefit*, the *member* shall be eligible to receive *benefits* under the standard eyeglass lenses *benefit* or the eyeglass frame *benefit* only after the contact lenses *benefit* frequency has ended.

2. Payment will be made for either eyeglass lenses or contact lenses within a *benefit period*. Payment will not be made for both.

3. *In-network providers* are not contractually obligated to offer sale prices in addition to the out lined *coverage*.

4. Regardless of *optical necessity*, vision *benefits* are not available more frequently than specified in the **Summary of Benefits** section.

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Benefits Booklet*, we will not provide *benefits* under this *coverage* for the following services, supplies or charges;

1. Services or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury;
3. Charges for which benefits or services are provided to you by any hospital, medical or vision service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
4. Services provided or supplies furnished or devices started prior to your effective date of *coverage*;
5. Treatment or supplies which you would have no legal obligation to pay;
6. Professional services and/or materials in connection with blended bifocals, no line, or progressive addition lenses; compensated or special multi-focal lenses; plain (non-prescription) lenses; anti-reflective, scratch, UV400, or any coating of lamination applied to lenses; and tints other than solid;
7. Examinations or materials which are not listed herein as a covered service;
8. Medical attention or surgical treatment of the eye, eyes or supporting structures;
9. Drugs or any other medications;
10. Procedures determined to be special or unusual (orthoptics, vision training, tonography, etc.);
11. *Vision examinations* or materials required for employment;
12. V*ision examinations* or materials sponsored by the *subscriber's* employer without charge to the *subscriber*;
13. Duplicate and temporary devices, appliances, and services;
14. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, unless you would otherwise meet the frequency limitations;
15. Parts or repair of frames;
16. Lenses which do not require a prescription;
17. Sunglasses;
18. Two pair of glasses in lieu of bifocals;
19. Low vision aids (i.e., magnifying glasses to help people with severe sight issues);
20. Industrial safety lenses and safety frames with or without side shields;
21. Services incurred after your termination date of coverage except as provided for in this *Benefits Booklet*;

22. Services received in a country with which United States law prohibits transactions;
23. Charges that exceed the *allowance amount;*
24. Cost-sharing amounts you must pay as outlined in this Benefits Booklet;
25. Travel expenses incurred together with *benefits*;
26. Court ordered services when not of *optical necessity* and/or not a covered *benefit*;
27. 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 under law;
28. Services not billed by an eligible *provider;*
29. Vision services rendered by a *provider* who is a member of your *immediate family*;
30. Telephone and electronic consultations, including virtual services, between you and a *provider*;
31. Charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of vision records, or for your decision to cancel a vision procedure;
32. Any other service or treatment, except as provided in this *Benefits Booklet*.

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

This section explains when and why your *coverage* with us may end.

Termination of Group Contract

When the group contract ends, it automatically terminates *coverage* for all *members* in the group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of Coverage for Members

You cannot be terminated based on health status, health care need, or the use of our *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. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child - *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* 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 us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA (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 us.

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.

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 us. The claim is based upon the itemized statement of charges for vision services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which we 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 us.

In-Network providers

When you receive services and/or supplies from an *in-network provider*, you should show their *member ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* is made directly to the *in-network provider*.

Out-of-Network providers

If you visit an out-of-network *provider*, you may be required to pay for the service and/or supplies at the time it is rendered. Although some *out-of-network providers* file claims on behalf of our *members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made.

Allowance Amount

The *benefit* payment amount is based on the *allowance amount* on the date the service is rendered or on the date the expense is deemed incurred by *Capital*.

Filing A Claim

Capital does not require any special vision claim form. *In-network providers* will fill out and submit the claims. Some *out-of-network providers* may also provide this service upon request. If you receive services from an *out-of-network provider* who does not provide this service, you can submit your own claim directly to us at the mailing address listed below. A separate claim form must be completed for each *member* who received vision services. For your convenience, you can print a claim form from our website at CapitalBlueCross.com.

BlueCross *Vision*
c/o National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Members must also provide additional information, if applicable, including but not limited to, other insurance payment information. If you need help submitting a vision claim you can contact Customer Service at **1-800-905-4102**.

We will contact you and/or the *provider* if additional information is needed.

Out-of-Country Claims

When you obtains vision services outside of the United States, you must pay for the treatment at the time of service, get a detailed receipt from the treating provider, and then submit the claim to us.

In addition to providing the provider's name and address (including country), the receipt should describe the *vision* services performed by the provider. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of this vision coverage, and is based on the out-of-network benefit provided through the group contract.

Claim Filing and Processing Time Frames

Time Frames for Submitting Vision Claims

All claims must be submitted within 12 months from the date of service.

Time Frames Applicable to Vision Claims

If your claim involves a vision service or supply that was already received, we will process the claim within 30 days of receiving the claim. We may extend the 30-day time period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

The coordination of *benefits* provision 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 , 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 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 vision benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when you have 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 percent of the total Allowable Expense deemed customary and reasonable by *Capital*.

Covered Service: A service or supply specified in This Coverage for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage.

We will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This Coverage.

The payment of *benefits* under This Coverage shall be affected by the benefits that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a 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 you 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:

- 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 you.
- 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 you.
- 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 you have failed to comply with the Plan provisions.

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.

      (i) 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.

   b. Child Covered Under More Than One Plan.

      (i) 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:

      (ii) 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.

      (iii) 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.

      (iv) 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. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent "rule can determine the order of benefits.

d. *COBRA* or State Continuation Coverage.

If a *member* whose coverage is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other 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. We may obtain and use the facts it needs to apply these rules and determine benefits payable under This Coverage and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by *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, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. We will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability/Subrogation

Subrogation is the right of the *contract holder* to recover the amount it has paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in *the contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made In Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the benefits under your vision *coverage*.

To Appeal an Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract*;
- Not provided because it is determined to be *investigational* or not of *optical necessity*.

If you disagree with an adverse benefit determination with respect to *benefits* available under your coverage you may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

Your appeal must be sent to:

BlueCross *Vision*
c/o National Vision Administrators
1200 Route 46 West
Clifton, NJ 07013

You have the right to submit written comments, documents, records, and other information relating to your claim for *benefits*. You also have the right to receive, upon request and free of charge, copies of all documents, records, and other information related to your adverse benefit determination. A request for information does **not** constitute an appeal. To receive copies of this information, requests should be mailed to the above listed address.

If the notice of an adverse benefit determination advises you to submit additional information in order to perfect the claim, then you should make arrangements to submit all requested information if and when you file an appeal. Failure to promptly submit any additional information may result in the denial of your appeal.

The following time frames apply to our review of your appeal. We will notify you of our decision within:

- 60 days of receiving your appeal if the appeal involves a vision claim and you file the appeal after receiving the vision service.
- 30 days of receiving your *a*ppeal if you file an appeal prior to receiving the vision service.

If your coverage is an employer-sponsored group plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) and if you remain dissatisfied upon completion of the mandatory appeal process described above, you have the right to bring a civil action under ERISA Section 502(a).

Designating an Individual to Act On Your Behalf

You may designate another individual to act on your behalf in pursuing a *benefit* claim or appeal of an unfavorable *benefit* decision.

To designate an individual to serve as your “authorized representative”, you must complete, sign, date, and return a Member Authorization Form. You may request this form from our Member Service Department at **1-800-905-4102**.

We communicate with your authorized representative only after we receives the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

GENERAL PROVISIONS

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *this coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between us and *contract holder* without the consent or concurrence of the *members*. By electing us or accepting our *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 thirty (30) 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 thirty (30) 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 *member* portion of cost, 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 thirty (30) days prior to the effective date of any change in coverage for *benefits.*

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.

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in policy or underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

Conformity With State Statues

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 non-use of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's* enrollment to a particular *provider*. If the *member's in-network 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 *Benefits Booklet* shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Member ID Cards

Capital provides *member ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member ID card* must be presented when service is requested.

Member ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, member *ID cards* must be returned to us within 31 days of the *member's* termination. *Member ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 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 legal notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest address reflected in *Capital's* records.
- If to the *contract holder*: to the latest address electronic and/or physical provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Health care *providers* maintain direct relationship with *members* and are solely responsible to *members* for all medical and/or vision services. The relationship between *Capital* and health care *providers* 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 an in-network *provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Physical Examination

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.

Applicable Group Numbers

Vision Plan 27 Professional

July 2021

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Colonial Intermediate Unit #20	00521915