



Capital BlueCross is an Independent Licensee
of the BlueCross BlueShield Association

PPO

GROUP PREFERRED PROVIDER CERTIFICATE OF COVERAGE

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

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WELCOME

INTRODUCTION

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

THE CAPITAL BLUECROSS FAMILY OF COMPANIES

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

- Capital Advantage Insurance Company[®], a subsidiary of Capital BlueCross, offers CareConnect (Gatekeeper PPO), SeniorBlue PPO[®] (a Medicare Advantage plan), and Senior (*Medicare* complementary) coverages.
- Capital Advantage Assurance Company[®], a subsidiary of Capital BlueCross, offers Preferred Provider Organization (PPO), Traditional, Comprehensive, Prescription Drug, Dental (BlueCross *Dentalsm*) and Vision (BlueCross *Visionsm*) coverages.
- Keystone Health Plan[®] Central, a subsidiary of Capital BlueCross, offers Health Maintenance Organization (HMO) and SeniorBlue HMO[®] (a Medicare Advantage plan) coverages.

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

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

HOW TO USE THIS DOCUMENT

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

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

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

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

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

- **Schedule of Preventive Care Services**, which outlines the preventive care *benefits* available under this *coverage*.
- **Preauthorization Program**, which outlines the services requiring *preauthorization*.
- **Disease/Condition Management Programs**, which outlines the Disease Management Programs offered to *members*.
- **How to File an Appeal**, which outlines how to appeal an *adverse benefit determination*.

IMPORTANT NOTICES

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

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

HOW TO CONTACT US

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

TELEPHONE

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

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

Telephone: 1-800-962-2242

Telephone (TTY): 711

Physical Disabilities

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

PREAUTHORIZATION OR OTHER CLINICAL MANAGEMENT PROGRAMS

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

INTERNET AND ELECTRONIC MAIL (E-MAIL)

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

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

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

MAIL

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

Capital BlueCross
PO Box 779519
Harrisburg, PA 17177-9519

Fax: 717-541-6915

IN PERSON

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

2500 Elmerton Avenue
Harrisburg, PA 17177

or

1221 W. Hamilton Street
Allentown, PA 18102

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

Members may also call or visit our Retail Center location Monday through Saturday 10:00 am to 7:00 pm at:

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

1-855-505-CARE (2583)

capitalbluestore.com

LANGUAGE ASSISTANCE

Capital offers language assistance for non-English speaking *members*. Language assistance includes interpreting services provided directly in the *member's* preferred language and document translation services available upon request. Language assistance is also available to disabled *members*. Information in Braille, large print or other alternate formats are available upon request.

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

HOW TO ACCESS BENEFITS

MEMBER IDENTIFICATION CARD (ID CARD)

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

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

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

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

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

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

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

OBTAINING BENEFITS FOR HEALTH CARE SERVICES

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

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

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

Services Provided by Participating Providers

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

All *participating providers* must seek payment, other than *cost-sharing amounts*, directly from *Capital*. ***Participating providers may not seek payment from members for services that qualify as benefits.*** However,

a *participating provider* may seek payment from *members* for non-covered services, including specifically excluded services (e.g. *cosmetic procedures*, etc.), or services in excess of *benefit lifetime maximums* and *benefit period maximums*. The *participating provider* must inform *members* prior to performing the non-covered services that they may be liable to pay for these services, and the *members* must agree to accept this liability.

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

OUT-OF-AREA SERVICES

Capital has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever *members* obtain healthcare services outside of *Capital's service area*, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the *BlueCard Program*.

Typically, when accessing care outside *Capital's service area*, *members* will obtain care from healthcare *providers* that have a contractual agreement (i.e., are “*participating providers*”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, *members* may obtain care from non-participating healthcare *providers*. *Capital's* payment practices in both instances are described below.

BlueCard® Program

Under the *BlueCard Program*, when *members* access covered healthcare services within the geographic area served by a Host Blue, *Capital* will remain responsible for fulfilling *Capital's* contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare *providers*.

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price *Capital* uses for a *member's* claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to this calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, *Capital* would then calculate *member* liability for any covered healthcare services according to applicable law.

How To Access Benefits

If *members* need service outside of the *Capital service area*, they can call 1-800-810-BLUE or visit www.bcbs.com to find a *Host Blue participating provider*.

Non-Participating Healthcare Providers Outside Capital's Service Area

Member Liability Calculation – When covered healthcare services are provided outside of *Capital's service area* by non-participating healthcare *providers*, the amount *members* pay for such services will generally be based on either the Host Blue's non-participating healthcare *provider* local payment or the pricing arrangements required by applicable state law. In these situations, *members* may be liable for the difference between the amount that the non-participating healthcare *provider* bills and the payment *Capital* will make for the covered services as set forth in this paragraph.

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

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

Out-of-Country Services

BlueCard Worldwide provides *members* with access to medical assistance services around the world. *Members* traveling or residing outside of the United States have access to doctors and *hospitals* in more than 200 countries and territories.

Members who are traveling outside the United States should remember to always carry their *Capital identification card*. If non-emergency care is needed, *members* can call 1-800-810-BLUE. An assistance coordinator, in conjunction with a medical professional, will assist *members* in locating appropriate care. The BlueCard Worldwide Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week. Also, *members* can call *Capital* to obtain *preauthorization* if services require *preauthorization*. BlueCard Worldwide providers are not obligated to request *preauthorization* of services. Obtaining *preauthorization*, where required, is the *member's* responsibility. *Members* should refer to the **Preauthorization Program** attachment to this *Certificate of Coverage* for more information. The telephone number to obtain *preauthorization* is 1-800-471-2242.

Members who need emergency care should go to the nearest *hospital*. If admitted, *members* should call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect (1-804-673-1177).

To locate *Host Blue participating providers* outside the United States, *members* can call BlueCard Worldwide Service Center 1-800-810-BLUE 24 hours a day, 7 days a week, or visit www.bcbs.com.

Services Provided by Non-Participating Providers

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

Services provided by *non-participating providers* may require higher *cost-sharing amounts* or may not be covered *benefits*. If such services are covered, *benefits* will be reimbursed at a percentage of the *allowable amount*

applicable to this *coverage* with *Capital*. Information on whether *benefits* are provided when performed by a *non-participating provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

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

Emergency Services

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

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

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

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

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

SUMMARY OF COST-SHARING AND BENEFITS

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

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

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

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

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

SUMMARY OF COST-SHARING		
	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Preauthorization Penalty	Applicable only to <i>BlueCard Program participating providers</i>	20%
Copayments		
<ul style="list-style-type: none"> • Office Visits 	\$20 <i>copayment</i> per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician \$30 <i>copayment</i> per visit for all other <i>professional providers</i>	Not Applicable
<ul style="list-style-type: none"> • Radiology Services (Outpatient Facility only) 	Paid in Full for outpatient facility procedures for high tech radiology tests (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.) Paid in Full for outpatient facility procedures for radiology tests other than high-tech radiology tests.	Not Applicable
<ul style="list-style-type: none"> • Emergency Room 	\$100 <i>copayment</i> per visit, waived if admitted	
<ul style="list-style-type: none"> • Urgent Care 	\$50 <i>copayment</i> per visit	Not Applicable
<ul style="list-style-type: none"> • Inpatient (Per Admission) 	Not Applicable	Not Applicable

Summary of Cost-Sharing and Benefits

SUMMARY OF COST-SHARING		
	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Deductible (per benefit period)	\$500 per <i>member</i> \$1,000 per family	\$1,000 per <i>member</i> \$2,000 per family
	<p>The <i>deductible</i> does not apply to the following <i>benefits</i>:</p> <ul style="list-style-type: none"> • <i>Emergency services</i>; • <i>Emergency ambulance services</i>; • <i>Annual screening mammograms</i>; • <i>Annual screening gynecological examinations</i>; • <i>Annual screening Papanicolaou smears</i>; • <i>Pediatric preventive care (participating providers only)</i>; • <i>Pennsylvania mandated childhood immunizations</i>; • <i>Adult preventive care (participating providers only)</i>; • <i>Outpatient substance abuse services (participating providers only)</i> • <i>Covered nutritional supplements</i>; and • <i>Home health care visits related to childbirth</i>. 	
Coinsurance	Not Applicable	20% <i>coinsurance</i> *
Out-of-Pocket Maximum	\$6,600 per <i>member</i> \$13,200 per family	\$6,600 per <i>member</i> \$13,200 per family
<p>When the out-of-pocket maximum is reached, payment for all other benefits during the remainder of the benefit period are made at 100% of the allowable amount, except for non-participating facility providers, which remain at the percentage of the allowable amount indicated in the Payment Levels for Facility Providers chart in this Summary of Benefits and Cost-Sharing section.</p> <p>This <i>out-of-pocket maximum</i> amount is combined with, and not in addition to, the <i>out-of-pocket maximum</i> amount reflected in the Rx Plan Certificate of Coverage. This combined <i>out-of-pocket maximum</i> amount can be satisfied with eligible amounts incurred for medical <i>benefits</i>, prescription drug <i>benefits</i>, or a combination of the two.</p>	<p>The following expenses do not apply to the <i>out-of-pocket maximum</i>:</p> <ul style="list-style-type: none"> • <i>Preauthorization penalties</i>; • <i>Charges exceeding the allowable amount</i>; and • <i>Expenses incurred for payment of a benefit after any applicable benefit period maximum has been exhausted</i>. 	

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

Summary of Cost-Sharing and Benefits

SUMMARY OF PAYMENT LEVELS FOR FACILITY PROVIDERS		
	Amounts Members Are Responsible For:	
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>
Ambulance (non-emergency)	Paid in Full	20% coinsurance
<i>Ambulatory Surgical Facility</i>	Paid in Full	Not covered
<i>Birthing Facility</i>	Paid in Full	50% coinsurance
Durable Medical Equipment Supplier	Paid in Full	20% coinsurance
<i>Emergency Services</i>	Paid in Full	Paid in Full
<i>Freestanding Diagnostic Facility</i>	Paid in Full	20% coinsurance
<i>Freestanding Dialysis Facility</i>	Paid in Full	Not covered
<i>Home Health Care Agency</i>	Paid in Full	50% coinsurance
<i>Hospice</i>	Paid in Full	20% coinsurance
<i>Hospital</i>	Paid in Full	50% coinsurance
<i>Hospital Laboratory</i>	Paid in Full	50% coinsurance
Infusion Therapy Provider	Paid in Full	20% coinsurance
<i>Long Term Acute Care Hospital</i>	Paid in Full	Not covered
Orthotic Supplier	Paid in Full	20% coinsurance
Prosthetic Supplier	Paid in Full	20% coinsurance
Psychiatric Hospital	Paid in Full	50% coinsurance
<i>Psychiatric Partial Hospitalization Facility</i>	Paid in Full	50% coinsurance
<i>Rehabilitation Hospital</i>	Paid in Full	50% coinsurance
<i>Skilled Nursing Facility</i>	Paid in Full	50% coinsurance
<i>Substance Abuse Treatment Facility</i>	Paid in Full	50% coinsurance
<i>Urgent Care Services</i>	Paid in Full	20% coinsurance

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart <u>in addition to the coinsurance percentage reflected in this Summary of Benefits chart</u>. <i>Non-participating providers</i> may balance bill <i>members</i>.***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES			
<i>Acute Care Hospital</i>	Paid in Full	50% <i>coinsurance</i>	
<i>Long Term Acute Care Hospital</i>	Paid in Full	Not covered	
BLOOD AND ADMINISTRATION			
<i>Benefits</i>	Paid in Full, after units deductible	20% <i>coinsurance</i> , after units deductible	3 unit deductible per <i>benefit period</i>
ACUTE INPATIENT REHABILITATION			
<i>Benefits</i>	Paid in Full	50% <i>coinsurance</i>	60 days per <i>benefit period</i>
SKILLED NURSING FACILITY			
<i>Benefits</i>	Paid in Full	50% <i>coinsurance</i>	100 days per <i>benefit period</i>
PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) AND CONSULTATIONS			
<i>Inpatient E&M</i>	Paid in Full	20% <i>coinsurance</i>	
<i>Outpatient E&M (Office Visit)</i>	\$20 <i>copayment</i> per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician \$30 <i>copayment</i> per visit for all other <i>professional providers</i>	20% <i>coinsurance</i>	
<i>Inpatient Consultations</i>	Paid in Full	20% <i>coinsurance</i>	
<i>Outpatient Consultations</i>	\$20 <i>copayment</i> per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician \$30 <i>copayment</i> per visit for all other <i>professional providers</i>	20% <i>coinsurance</i>	
TRANSPLANT SERVICES			
Evaluation, Acquisition and Transplantation	Paid in Full	20% <i>coinsurance</i>	
Blue Distinction Centers for Transplant (BDCT) Travel Expenses	Paid in Full	Not covered	\$10,000 per transplant episode

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart <u>in addition to the coinsurance percentage reflected in this Summary of Benefits chart</u>. <i>Non-participating providers</i> may balance bill <i>members</i>. ***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
SURGERY			
Evaluation & Management	\$20 <i>copayment</i> per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician \$30 <i>copayment</i> per visit for all other <i>professional providers</i>	20% <i>coinsurance</i>	
Surgical Procedure	Paid in Full	20% <i>coinsurance</i>	
Anesthesia	Paid in Full	20% <i>coinsurance</i>	
Mastectomy and Related Services	Paid in Full	20% <i>coinsurance</i>	
Oral Surgery	Paid in Full	20% <i>coinsurance</i>	
MATERNITY SERVICES			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
INTERRUPTION OF PREGNANCY			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
NEWBORN CARE			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
DIAGNOSTIC SERVICES			
Radiology Tests (Outpatient Facility Only)	Paid in Full for outpatient facility procedures for high tech radiology tests (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.) Paid in Full for outpatient facility procedures for radiology tests other than high-tech radiology tests.	20% <i>coinsurance</i>	
Laboratory Tests	Paid in Full	20% <i>coinsurance</i>	
Medical Tests	Paid in Full	20% <i>coinsurance</i>	

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart <u>in addition to the coinsurance percentage reflected in this Summary of Benefits chart</u>. <i>Non-participating providers</i> may balance bill <i>members</i>. ***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
ALLERGY SERVICES			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
OUTPATIENT THERAPY SERVICES			
Physical Medicine	\$30 <i>copayment</i> per visit	20% <i>coinsurance</i>	
Occupational Therapy	\$30 <i>copayment</i> per visit	20% <i>coinsurance</i>	30 visits per <i>benefit period</i>
Speech Therapy	\$30 <i>copayment</i> per visit	20% <i>coinsurance</i>	30 visits per <i>benefit period</i>
Respiratory Therapy	\$30 <i>copayment</i> per visit	20% <i>coinsurance</i>	30 visits per <i>benefit period</i>
Cardiac Rehabilitation Therapy	Paid in Full	20% <i>coinsurance</i>	
Manipulation Therapy	\$30 <i>copayment</i> per visit	20% <i>coinsurance</i>	
RADIATION THERAPY			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
DIALYSIS TREATMENT			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
OUTPATIENT CHEMOTHERAPY			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
EMERGENCY AND URGENT CARE SERVICES			
<p><i>Emergency Services</i></p> <p>Consultations received in the emergency room are subject to the applicable <i>outpatient</i> consultation <i>copayment</i>.</p> <p><i>Inpatient hospital stays</i> as a result of an emergency are reimbursed at the level of payment for <i>inpatient benefits</i>.</p>	<p>Paid in Full; <i>deductible</i> waived.</p> <p>\$100 <i>copayment</i> per visit, waived if admitted <i>inpatient</i></p> <p>Note: Cost share is the same regardless of whether the emergency services are provided by a <i>Participating Provider</i> or a <i>Non-Participating Provider</i>.</p>		
<i>Urgent Care Services</i>	\$50 <i>copayment</i> per visit	20% <i>coinsurance</i>	
MEDICAL TRANSPORT			
Emergency Ambulance	<p>Paid in Full, <i>deductible</i> waived</p> <p>Note: Cost share is the same regardless of whether the emergency services are provided by a <i>Participating Provider</i> or a <i>Non-Participating Provider</i>.</p>		

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart <u>in addition to the coinsurance percentage reflected in this Summary of Benefits chart</u>. <i>Non-participating providers</i> may balance bill <i>members</i>. ***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
Non-Emergency Ambulance	Paid in Full	20% <i>coinsurance</i>	
MENTAL HEALTH CARE SERVICES			
<i>Inpatient Services</i>	Paid in Full	20% <i>coinsurance</i>	
<i>Partial Hospitalization</i>	Paid in Full	20% <i>coinsurance</i>	
<i>Outpatient Services</i>	\$20 <i>copayment</i> per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician \$30 <i>copayment</i> per visit for all other <i>professional providers</i>	20% <i>coinsurance</i>	
SUBSTANCE ABUSE SERVICES			
Detoxification - <i>Inpatient</i>	Paid in Full	20% <i>coinsurance</i>	
Rehabilitation – <i>Inpatient</i>	Paid in Full	20% <i>coinsurance</i>	
Rehabilitation - <i>Outpatient</i>	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i>	
HOME HEALTH CARE SERVICES			
<i>Benefits</i>	Paid in Full	50% <i>coinsurance</i>	90 visits per <i>benefit period</i>
INFUSION/IV THERAPY			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
HOSPICE CARE			
<i>Benefits</i> (includes <i>Residential Hospice Care</i>)	Paid in Full	20% <i>coinsurance</i>	10 days <i>inpatient</i> or 240 hours <i>outpatient</i> respite care and <i>residential hospice care</i> .
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Paid in Full	20% <i>coinsurance</i>	
Wigs	Paid in Full	Paid in Full	\$300 <i>benefit lifetime maximum</i>

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart <u>in addition to</u> the <i>coinsurance</i> percentage reflected in this Summary of Benefits chart. <i>Non-participating providers</i> may balance bill <i>members</i>. ***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
ORTHOTIC DEVICES			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
DIABETIC SUPPLIES AND EDUCATION			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
ENTERAL NUTRITION			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
IMMUNIZATIONS AND INJECTIONS			
<i>Benefits</i>	Paid in Full	20% <i>coinsurance</i>	
MAMMOGRAMS			
Screening Mammogram	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i> , <i>deductible</i> waived	
Diagnostic Mammogram	Paid in Full	20% <i>coinsurance</i>	
GYNECOLOGICAL SERVICES			
Screening Gynecological Exam	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i> , <i>deductible</i> waived	
Screening Pap Smear	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i> , <i>deductible</i> waived	
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care (includes physical examinations, childhood immunizations and tests)	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i> , <i>deductible</i> waived for Pennsylvania mandated childhood immunizations	
Adult Preventive Care (includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law)	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i>	

Summary of Cost-Sharing and Benefits

SUMMARY OF BENEFITS			
<p>*** It is important for <i>members</i> to refer to the Payment Levels for Facility Providers chart to determine the level of payment for <i>facility providers</i>. <i>Members</i> will be responsible for paying the <i>coinsurance</i> percentage reflected in that chart in addition to the <i>coinsurance</i> percentage reflected in this Summary of Benefits chart. <i>Non-participating providers</i> may balance bill <i>members</i>. ***</p>			
	Amounts Members Are Responsible For:		Limits and Maximums (If Applicable)
	<i>Participating Providers</i>	<i>Non-Participating Providers</i>	
OTHER SERVICES			
Contraceptives	Paid in Full, <i>deductible</i> waived	20% <i>coinsurance</i>	Limited to coverage for those prescribed contraceptive products or devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Orthodontic Treatment of Congenital Cleft Palates	Paid in Full	20% <i>coinsurance</i>	
Diagnostic Hearing Screening	Paid in Full	20% <i>coinsurance</i>	
Vision Care for Illness or Accidental Injury	Paid in Full	20% <i>coinsurance</i>	
Infertility Services	Paid in Full	20% <i>coinsurance</i>	
Non-Routine Foot Care	Paid in Full	20% <i>coinsurance</i>	
Routine Costs Associated with Approved Clinical Trials	Paid in Full	20% <i>coinsurance</i>	

COST-SHARING DESCRIPTIONS

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

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

APPLICATION OF COST-SHARING

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

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

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

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

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

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

PREAUTHORIZATION PENALTY

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

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

Cost-Sharing Descriptions

For Example: A particular service provided by a *non-participating provider* requires *preauthorization* before services are performed. If the *member* does not contact *Capital* to preauthorize this service, there is a \$300 *preauthorization penalty*. The *non-participating provider's* billed charge is \$400, and the *allowable amount* is \$350.

In this example, payment for the claim is calculated as follows:

1. Subtract the *preauthorization penalty* amount from the *allowable amount* to determine *Capital's* payment to the *member*, which, in turn, the *member* should pay directly to the *non-participating provider* ($\$350 - \$300 = \$50$).
2. Subtract *Capital's* payment to the *member* from the *non-participating provider's* charge to determine the *member's* total payment responsibility ($\$400 - \$50 = \$350$).

So, the *member* in this example would be responsible for paying the *non-participating provider* a total of \$400: \$50 received from *Capital* and \$350 from the *member*.

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

COPAYMENT

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

For Example: The charge for a particular service provided by a *participating provider* is set by the *participating provider's* contract with *Capital* to pay at an *allowable amount* of \$60. If the *member's* *coverage* includes a \$10 *copayment*, the *participating provider* will collect \$10 from the *member* at the time services are performed. This *copayment* is part of the *allowable amount* for the *benefit* provided under the *member's* *coverage*. Since the *participating provider* already received \$10 from the *member*, *Capital* will reimburse the *participating provider* a maximum of \$50 for the service. The *participating provider* still receives the total *allowable amount* of \$60; it is just shared between the *member* and *Capital*.

In this example, payment for the claim is calculated as follows:

Subtract the *copayment* paid by the *member* from the *allowable amount* to determine *Capital's* payment to the *participating provider* ($\$60 - \$10 = \$50$).

The *member* in this example would be responsible for paying the *participating provider* \$10, and *Capital* would be responsible for paying the *participating provider* \$50. So, in the end, the *participating provider* receives a total of \$60 (the *allowable amount*).

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

DEDUCTIBLE

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

Cost-Sharing Descriptions

For Example: The charge for a particular service provided by a *participating provider* is set by the *participating provider's* contract with *Capital* to pay at an *allowable amount* of \$60. If the *member's* coverage includes a \$500 *deductible* for *participating provider* benefits, and assuming a *copayment* is not applied, the *member* is responsible for this \$60. The *participating provider* will collect this amount from the *member*. *Capital* will then apply this \$60 towards the \$500 *deductible* applicable to the *member's* coverage. So, on the *member's* \$500 *deductible*, the remaining *deductible* amount which must be met would be \$440.

In this example, payment for the claim is calculated as follows:

Subtract the *allowable amount* from the *member's* total *deductible* amount to determine the remaining *deductible* amount the *member* must meet ($\$500 - \$60 = \$440$).

For each *deductible* amount (participating and non-participating) that may apply to this *coverage*, two (2) *deductible* amounts may apply: an individual *deductible* and a family *deductible*. Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. Once the family *deductible* has been met, *benefits* will be paid for a family *member* regardless of whether that family *member* has met his/her individual *deductible*. In calculating the family *deductible*, *Capital* will apply the amounts satisfied by each *member* towards the *member's* individual *deductible*. However, the amounts paid by each *member* that count towards the family *deductible* are limited to the amount of each *member's* individual *deductible*.

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

COINSURANCE

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

For Example: The charge for a particular service provided by a *participating provider* is set by the *participating provider's* contract with *Capital* to pay at an *allowable amount* of \$60. Assuming no *copayment* is applied, any applicable *deductible* has been met, and the *member's* coverage includes a 10% *coinsurance* for *participating provider* services, the *allowable amount* of \$60 will be multiplied by 10%, which equals \$6. This \$6 will then be subtracted from the *allowable amount* of \$60, leaving \$54, which *Capital* will reimburse the *participating provider*. The *participating provider* will then collect the \$6 from the *member*.

In this example, payment for the claim is calculated as follows:

1. Multiply the *allowable amount* by the *coinsurance* percentage to determine the *member's* liability ($\$60 \times 10\% = \6).
2. Subtract the *coinsurance* amount from the *allowable amount* to determine *Capital's* payment to the *participating provider* ($\$60 - \$6 = \$54$).

The *member* in this example would be responsible for paying the *participating provider* \$6, and *Capital* would be responsible for paying the *participating provider* \$54. So, in the end, the *participating provider* receives a total of \$60 (the *allowable amount*).

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

Cost-Sharing Descriptions

For Example: A non-participating provider's billed charge is \$100 for a particular service provided by a non-participating provider. The allowable amount is \$60. No copayment is applied, the applicable deductible has been met, and the member's coverage includes a 20% coinsurance for non-participating provider services.

In this example, payment for the claim is calculated as follows:

1. Multiply the allowable amount by the coinsurance percentage to determine the member's coinsurance amount ($\$60 \times 20\% = \12).
2. Subtract the coinsurance amount from the allowable amount to determine Capital's payment to the member, which in turn, should be paid to the non-participating provider ($\$60 - \$12 = \$48$).
3. Subtract Capital's payment to the member from the non-participating provider's charge to determine the member's total payment responsibility ($\$100 - \$48 = \$52$).

So, the member in this example would be responsible for paying the non-participating provider a total of \$100: \$48 from Capital and \$52 from the member.

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

OUT-OF-POCKET MAXIMUM

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

For Example: Expanding on the previous coinsurance example for *participating providers*, the member owes the *participating provider* \$6 after coinsurance was applied to the allowable amount for the *benefits* provided under this coverage. This \$6 is the member's "out-of-pocket" expense. If the member's coverage includes an *out-of-pocket maximum* of \$1,000, this \$6 is applied to the \$1,000. The result is that the member must pay \$994 in additional out-of-pocket expenses during the *benefit period* before the coinsurance is waived and *benefits* pay at 100% of the allowable amount.

In this example, payment for the claim is calculated as follows:

Subtract the coinsurance amount from the member's total *out-of-pocket maximum* amount to determine the remaining *out-of-pocket maximum* amount the member must meet ($\$1,000 - \$6 = \$994$).

For each *out-of-pocket maximum* amount (participating and non-participating) that may apply to this coverage, two (2) *out-of-pocket maximum* amounts may apply: an individual *out-of-pocket maximum* and a family *out-of-pocket maximum*. Each member must satisfy the individual *out-of-pocket maximum* applicable to this coverage every *benefit period*. Once the family *out-of-pocket maximum* has been met, *benefits* will be paid for a family member regardless of whether that family member has met his/her individual *out-of-pocket maximum*. In calculating the family *out-of-pocket maximum*, Capital will apply the amounts satisfied by each member toward the member's individual *out-of-pocket maximum*. However, the amounts paid by each member that count towards the family *out-of-pocket maximum* are limited to the amount of each member's individual *out-of-pocket maximum*.

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

BENEFIT PERIOD MAXIMUM

A *benefit period maximum* is the limit of coverage placed on a specific *benefit(s)* provided under this coverage within a *benefit period*. Such limits on *benefits* may be in the form of visit limits, day limits, or dollar limits; and

Cost-Sharing Descriptions

there may be more than one limit on a specific *benefit*. This *coverage* has no dollar limits on Essential Health Benefits, as that term is defined by *PPACA*.

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

BENEFIT LIFETIME MAXIMUM

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

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

BALANCE BILLING CHARGES

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

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

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

For Example: The billed charge for an office visit is set by the doctor to be \$100. *Capital's allowable amount* for this service is \$60. If the doctor is a *participating provider* who has agreed to accept the *allowable amount*, minus any *cost-sharing amount* from the *member*, as payment in full, \$60 is the maximum dollar amount the *provider* will be reimbursed for this service; and the *member* will not be billed for the additional \$40.

- For *non-participating providers*, the *allowable amount* for a *benefit* determines the maximum amount *Capital* will pay a *member* for *benefits*. Since the *non-participating provider* does not have a contract with *Capital*, the *provider* has not agreed to accept *Capital's* payment, minus any *cost-sharing amount* due from the *member*, as payment in full. The *allowable amount* in these situations can be less than the *provider's charge*. Therefore, the *member* is also responsible for paying the difference between the *provider's billed charge* and the *allowable amount* in addition to any applicable *cost-sharing amount*. Unless otherwise agreed to by *Capital*, all payment for services performed by a *non-participating provider* will be made to the *member*.

For Example: The billed charge for an office visit is set by the doctor to be \$100. *Capital's allowable amount* for this service is \$60. Since the *non-participating provider* does not have a contract with *Capital* the *provider* can ask the *member* to pay the full \$100 charge. However, the maximum payment *Capital* will make to the *member* is the *allowable amount* of \$60. The remaining \$40 is the *member's expense*.

BENEFIT DESCRIPTIONS

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

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

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

ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

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

- A semi-private room (two or more beds);
- A bed in a *special accommodations unit*; or
- A private room, if *medically necessary* or if no semi-private accommodations are available. A private room is not *medically necessary* when used solely for the comfort and/or convenience of the *member*. When a private room is selected at the *member's* option, the *member* is responsible for paying ten percent (10%) of the hospital's private room charge.

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

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

Long-Term Acute Care Hospital

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

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.

ACUTE INPATIENT REHABILITATION

Benefits for acute *inpatient* rehabilitation provided in a *rehabilitation hospital* include services provided when a *member* requires an intensive level of skilled *inpatient* rehabilitation services on a daily basis and these skilled

rehabilitation services are provided in accordance with a *physician's* order. *Capital* must concur with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

SKILLED NURSING FACILITY

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

PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) AND CONSULTATIONS

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

Evaluation and Management

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

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

In certain situations a facility fee may be associated with an *outpatient* visit to a *professional provider*. *Members* should consult with the *provider* of the service to determine whether a facility fee may apply to that *provider*. An additional *cost sharing amount* may apply to the facility fee.

Consultations

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

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

Consultations that are not *benefits* include:

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

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

RETAIL CLINIC SERVICES

Benefits for services performed in a retail clinic include those that, in the judgment of the *provider*, can be treated by a duly licensed or certified associated physician or allied health professional practicing within the scope of his/her licensure, certification or specialty. *Retail clinic services* are performed in an ambulatory medical clinic

that provides a limited scope of services for preventive care or the treatment of minor injuries and illnesses and is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends. *Benefits* for *retail clinic services* are calculated at the same benefit level as professional provider outpatient E&M office visits.

TRANSPLANT SERVICES

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

Pre-Transplant Evaluation

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

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

Acquisition and Transplantation

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

- When the transplant requires surgical removal of the donated part from a living donor and both the recipient and donor are covered by *Capital*, *benefits* are provided to both, each pursuant to the terms of each person's respective contract.
- If only the transplant recipient is covered by *Capital*, *benefits* are provided for the recipient and for the donor, but only to the extent that donor benefits are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's coverage.
- If the transplant recipient is covered by *Capital* and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

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

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

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

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

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

Post-Transplant Services

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

Blue Distinction Centers for Transplant (BDCT)

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

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

SURGERY

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

Evaluation & Management (E&M)

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

Surgical Procedure

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

Anesthesia Related to Surgery

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

Benefits also include 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 non-covered dental procedures or non covered oral surgery for *members* who are seven (7) years of age or younger and *members* who are developmentally disabled, provided *Capital* has determined services to be *medically necessary* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. Anesthesia and all related *benefits* for *members* seven (7) years of age or younger and *members* who are developmentally disabled are subject to all applicable *cost-sharing amounts*.

Mastectomy and Related Services

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

Oral Surgery

Benefits for oral *surgery* include surgical extractions of full or partial bony impactions, root recovery, surgical exposure of impacted or unerupted teeth, fractures and dislocations of the face or jaw, surgical excisions (e.g., cysts, tori, exostosis), to improve function, dental implants when major disease, trauma, or surgery results in insufficient bony structure to support dentures or other oral prosthetics in order to chew, and lingual frenulum repairs.

Orthognathic *surgery* is limited to conditions resulting in significant functional impairment, and repair of traumatic injuries.

Anesthesia charges associated with oral surgery are covered for *members* who are seven (7) years of age or younger and *members* who are developmentally disabled when determined by *Capital* to be *medically necessary* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. Anesthesia and all related *benefits* for *members* seven (7) years of age or younger and *members* who are developmentally disabled are subject to all applicable *cost-sharing amounts*.

Other Surgeries

Benefits for other specialized surgical procedures include:

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

MATERNITY SERVICES

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

Prenatal Services

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

Delivery

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

Under federal law, 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, under federal law, 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, under federal law, require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain

providers or facilities, or to reduce out-of-pocket costs, members may be required to obtain precertification. For information on precertification, contact the plan administrator.

Postpartum Services

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

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 non-elective or elective.

NEWBORN CARE

*Benefits for newborn care include ordinary nursery care and physical examinations of the newborn infant while the mother is an inpatient; prematurity services; preventive health care services; and services to treat an injury or illness, including care and treatment of medically diagnosed congenital defects and birth abnormalities. Refer to the **Membership Status** section for limitations on newborn care coverage.*

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

DIAGNOSTIC SERVICES

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

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.

Laboratory Tests

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

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.

Other Diagnostic Tests and Services

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

ALLERGY SERVICES

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

Testing

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

Immunotherapy

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

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

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

Allergy Serums

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

THERAPY SERVICES

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

Physical Medicine

Benefits for physical medicine 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.

Maintenance physical medicine is not covered.

Occupational Therapy

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

Maintenance occupational 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.

Maintenance speech therapy is not covered.

Respiratory Therapy

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

Maintenance respiratory therapy is not covered.

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 therapy is not covered.

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.

Maintenance manipulation therapy is not covered.

RADIATION THERAPY

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

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.

CHEMOTHERAPY

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

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

EMERGENCY AND URGENT CARE SERVICES

An *emergency service* is any health care service provided to a *member* after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

Inpatient hospital stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*. Consultations received in the emergency room are subject to the applicable *outpatient consultation copayment*.

Benefits for emergency dental accident services include treatment required only to stabilize the *member* immediately following an accidental injury. Treatment of accidental injuries resulting from chewing or biting is not covered.

If *Capital*, upon reviewing the emergency room records, determines that the services provided do not qualify as *emergency services*, those non-emergency 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 non-life threatening and urgent and can be treated on other than an inpatient hospital basis and are performed at a freestanding urgent care center by a duly licensed associated physician or allied health professional practicing within the scope of his/her licensure and specialty. *Urgent care services* are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends.

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 non-emergency situations.

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

Emergency Ambulance

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

Non-Emergency Ambulance

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

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

MENTAL HEALTH CARE SERVICES

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

Inpatient Services

Benefits for *inpatient mental health care* services include bed, board and general *inpatient* nursing services when provided for the treatment of *mental illness*. Services provided by a *professional provider* to a *member* who is an *inpatient* for *mental health care* are also covered.

Partial Hospitalization

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

The *partial hospitalization* program must be approved by *Capital* or its designee. *Partial hospitalization mental health care* is not covered for halfway houses and residential treatment facilities.

Outpatient Services

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

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

SUBSTANCE ABUSE SERVICES

Substance abuse 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 abuse* includes detoxification and rehabilitation.

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 under the supervision of a licensed *physician* and in a facility licensed by the state in which it is located.

Rehabilitation

Benefits for *substance abuse* rehabilitation include services to assist *members* with a diagnosis of *substance abuse* in overcoming their addiction. *Members* must be detoxified before rehabilitation will be covered. A *substance abuse* treatment program provides rehabilitation care.

Inpatient — *Benefits* for *inpatient substance abuse* rehabilitation include: bed, board and general *inpatient* nursing services. *Substance abuse* care provided by a *professional provider* to a *member* who is an *inpatient* for *substance abuse* rehabilitation is also covered.

Residential treatment facilities are not covered other than sub-acute facilities when medical management services are provided.

Outpatient — *Benefits* for *outpatient substance abuse* rehabilitation include services that would be covered on an *inpatient* basis but are otherwise provided for *outpatient* or *partial hospitalization*.

To be eligible for *coverage*, these services must be provided by a *physician*, psychologist, or other eligible *provider* employed by a *substance abuse treatment facility*. Otherwise, *professional provider* services for *substance abuse* treatment are not eligible for *coverage* nor are these services eligible under *outpatient mental health care benefits*.

HOME HEALTH CARE SERVICES

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

Benefits for home health care services provided to a homebound patient include:

- Professional services provided by a registered nurse or licensed practical nurse;
- Physical medicine, occupational therapy and speech therapy;
- Medical and surgical supplies provided by the home health care agency; and
- Medical social service consultation.

No home health care *benefits* are provided for:

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

Home Health Care Visits Related to Mastectomies

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

Home Health Care Visits Related to Maternity

Benefits for home health care visits related to maternity include one (1) home health care visit within 48 hours after discharge when the discharge occurs prior to 48 hours of *inpatient* care following a normal vaginal delivery or prior to 96 hours of *inpatient* care following a cesarean delivery. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care *provider* whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the *provider*. Home health care visits following an *inpatient* stay for maternity services are not subject to *copayments*, *deductibles*, or *coinsurance*, if applicable to this *coverage*.

INFUSION/IV THERAPY

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

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

HOSPICE CARE

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

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

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

- Professional services provided by a registered nurse or *licensed practical nurse*;
- Palliative care by a *physician*;
- Medical and surgical supplies and durable medical equipment;
- Prescribed drugs related to the *hospice* diagnosis (drugs and biologicals);
- Oxygen and its administration;
- Therapies (physical medicine, occupational therapy, speech therapy);
- Medical social service consultations;
- Dietitian services;
- Home health aide services;
- Family counseling services;

Benefit Descriptions

- Respite care up to a maximum of ten (10) days in a *facility provider* or 240 hours of home respite care per *member* per lifetime;
- Continuous Home Care provided only during a period of crisis in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms; and
- *Inpatient* services of an acute medical nature arranged through the *hospice provider* in a hospital or skilled setting to address short-term pain and/or symptom control that cannot be managed in other settings.

Benefits for Residential Hospice Care include the following services provided to a *member* by a *hospice provider* responsible for the *member's* overall care:

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

No *hospice care benefits* are provided for:

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

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

DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES

Durable medical equipment consists of items that are:

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

- Appropriate for use in the home;
- Reusable; and
- Can withstand repeated use.

Examples of covered DME are wheelchairs, canes, walkers, and nebulizers when shown to be *medically necessary*. Examples of non-covered DME include but are not limited to iPads, home computers, laptops, and wearable activity or health monitors. Enteral pumps are only a covered DME when the enteral nutrition is considered *medically necessary*.

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

DME may be rented or purchased based upon:

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

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

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

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

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.

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.

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

DIABETIC SUPPLIES AND EDUCATION

Drugs and Supplies

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

Equipment, agents, and orthotics include:

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

Nutritional Counseling, Self-Management Training and Education

Benefits for nutritional counseling include counseling for the treatment of diabetes and for the treatment of obesity or morbid obesity.

Benefits for diabetes self-management training and education include participation in a diabetes self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Self-management education and education relating to diet, prescribed by a licensed *physician*, includes:

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

Benefit Descriptions

For *benefits* to be provided, the *member* must complete a diabetes education program that is:

- Conducted under the supervision of a licensed health care professional with expertise in diabetes;
- Approved by the American Diabetes Association or American Association of Diabetes Educators; and
- Subject to the criteria determined by *Capital*. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association or American Association of Diabetes Educators.

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 foods), as well as *medically necessary* enteral feeding equipment (e.g. pumps, tubing, etc).

Benefits for enteral nutrition products are included when administered by any method for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. Covered enteral nutrition products for these four conditions are exempt from *deductibles*.

Benefits for enteral nutrition products are also included for medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally or through a tube, and that provide fifty percent (50%) or more of total nutritional intake.

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.

IMMUNIZATIONS AND INJECTIONS

Benefits for immunizations and injections include certain immunizations if an individual is determined to be at high risk. *Capital* follows guidelines set by the Center for Disease Control in determining high-risk individuals. Immunizations for travel or for employment are not covered except as required by the Patient Protection and Affordable Care Act.

Injectables that are “primarily self administered” are not covered under the *member’s* medical *benefit* under any circumstances, even if the *member* is unable to self administer. In the event a *member* is unable to self administer an injectable medication, only the charges for the administration of the injectable will be covered when administered and reported by an eligible *provider* in an office, *hospital outpatient*, or home setting. *Members* can view the list of medications that *Capital* considers to be primarily self administered by accessing the Self Administered Medications Policy on the Capital BlueCross website at capbluecross.com.

MAMMOGRAMS

A mammogram is a radiological examination of the breast(s) used to detect tumors and cysts, and to help differentiate benign and malignant disease.

Screening Mammogram

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

Physician-recommended screening mammograms, regardless of age, are covered but may be subject to *cost-sharing amounts*.

Diagnostic Mammogram

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

GYNECOLOGICAL SERVICES

Screening Gynecological Exam

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

Screening Papanicolaou Smear

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

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

PREVENTIVE CARE SERVICES

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

Pediatric

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

Adult

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

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

PERVASIVE DEVELOPMENT DISORDERS (AUTISM SPECTRUM DISORDERS)

Autism spectrum disorders include any *pervasive development disorders* as defined by the Diagnostic and Statistical Manual of Mental disorders (DSM), including but not limited to autism, Asperger's Syndrome, childhood disintegrative disorder and Rett's Syndrome.

Benefits include coverage for the diagnostic assessment and treatment of *autism spectrum disorders* for members less than twenty-one (21) years of age.

Diagnostic Assessment

Diagnostic assessment of *autism spectrum disorders* consists of *medically necessary* assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has *autism spectrum disorder*. The diagnosis is valid for not less than twelve (12) months unless a licensed physician or psychologist determines an assessment is needed sooner.

Treatment

Treatment of *autism spectrum disorders* is identified in a treatment plan or functional behavioral assessment. A treatment plan must be submitted to *Capital*, or the *contract holder's* Managed Behavioral Healthcare Organization, that is:

- Developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation;
- Includes short and long-term goals which can be measured objectively;
- Includes any medically necessary pharmaceutical care, psychiatric care, psychological care, rehabilitative care and therapeutic care that is:
 - o Prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner; or
 - o Provided by an autism service provider; or
 - o Provided by a person, entity or group that works under the direction of an autism service provider.

Review of the treatment plan will be required by *Capital* prior to authorization of services. Treatment plans will be reviewed every six (6) months unless there is clear evidence of regression necessitating changes in treatment.

Coverage for the treatment of *autism spectrum disorders*, as prescribed in a specific treatment plan, include but are not limited to the following:

- *Medically necessary* medical therapy (e.g. physical therapy, occupational therapy, speech therapy) or psychotherapy specifically for the treatment of *pervasive developmental disorders*;
- *Medically necessary* behavior therapy and behavior modification including mobile therapy, behavior specialist consultation, therapeutic staff support;
- *Medically necessary* interventions to improve verbal and non-verbal communication skills;
- *Medically necessary* and appropriate treatment for comorbidities, including psychotherapy, behavioral therapy, physical and occupational therapy;

- Applied behavior analysis;
- Continued rehabilitative medical treatment once the therapeutic goals have been achieved to preserve the current level of function and prevent regression (maintenance).

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

Treatment and services that are provided as part of the *member's* Individual Education Plan (IEP) or as otherwise provided as part of the *member's* education are not covered.

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.

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.

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.

Diagnostic Hearing Screening

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

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

Vision Care for Illness or Accidental Injury

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

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

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

Infertility Services

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

However, treatments or procedures leading to or in connection with assisted fertilization are not covered.

Non-Routine Foot Care

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

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

Routine Costs Associated With Approved Clinical Trials

If a *member* is eligible to participate in an *Approved Clinical Trial* (according to the trial protocol), with respect to treatment of cancer or other life-threatening disease or condition, and either the *member's* referring *provider* is a *participating provider* who has concluded the *member's* participation in the trial would be appropriate, or the *member* furnishes medical and scientific information establishing that his or her participation in the trial would be appropriate, *benefits* shall be payable for *Routine Costs Associated with Approved Clinical Trials*. *Capital* must be notified in advance of the *member's* participation in the *Approved Clinical Trial*.

SCHEDULE OF EXCLUSIONS

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

1. Which are not *medically necessary* as determined by *Capital's* Medical Director(s) or his/her designee(s);
2. Which are considered by *Capital* to be *investigational*, except where otherwise required by law;
3. For any illness or injury which occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy and/or any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;
4. For any illness or injury suffered after the *member's effective date of coverage* which resulted from an act of war, whether declared or undeclared;
5. For services received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;
6. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or *group*;
7. For the cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy;
8. For items or services paid for by *Medicare* when *Medicare* is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary and the *member* so elects this *coverage* as primary;
9. For care of conditions that federal, state or local law requires to be treated in a public facility;
10. For court ordered services when not *medically necessary* and/or not a covered *benefit*;
11. For any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;
12. Which are not billed by and either performed by or under the supervision of an eligible *provider*;
13. For services rendered by a *provider* who is a member of the *member's immediate family*;
14. For telephone and electronic consultations between a *provider* and a *member*, including telemedicine services except for telemedicine services relating to genetic counseling;
15. For charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of medical records, or for a *member's* decision to cancel a *surgery*;

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16. For services performed by a *professional provider* enrolled in an education or training program when such services are related to the education or training program, including services performed by a resident *physician* under the supervision of a *professional provider*;
17. Which exceed the *allowable amount*;
18. Which are *cost-sharing amounts* required of the *member* under this *coverage*;
19. For the amount of any *preauthorization penalty* applied under the *preauthorization* provision of a *member's coverage*;
20. For which a *member* would have no legal obligation to pay;
21. For services incurred prior to the *member's effective date of coverage*;
22. For services incurred after the date of termination of the *member's coverage* except as provided for in this *Certificate of Coverage*;
23. For services received by a *member* in a country with which United States law prohibits transactions;
24. For *inpatient* admissions which are primarily for diagnostic studies or for *inpatient* services which could have been safely performed on an *outpatient* basis;
25. For prophylactic blood, cord blood or bone marrow storage in the event of an accident or unforeseen *surgery* or transplant;
26. For *custodial care*, domiciliary care, residential care, protective and supportive care including educational services, rest cures, convalescent care, or respite care not related to *hospice* services;
27. For services related to organ donation where the *member* serves as an organ donor to a non-member;
28. For transplant services where human organs were sold rather than donated and for artificial organs;
29. For anesthesia when administered by the assistant to the operating *physician* or the attending *physician*;
30. For *cosmetic procedures* or services related to *cosmetic procedures* performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the bodily part can be expected, except as otherwise required by law. This exclusion does not apply to *cosmetic procedures* or services related to *cosmetic procedures* performed to correct a deformity resulting from *birth defect* or accidental injury. For purposes of this exclusion, prior *surgery* is not considered an accidental injury;
31. For oral *surgery*, except as specifically provided in this *Certificate of Coverage*;
32. For maintenance therapy services, except as required by law;
33. For physical medicine for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;
34. For occupational therapy for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;
35. For speech therapy for the following conditions: psychosocial speech delay, behavior problems, intellectual disability (except when disorders such as aphasia or dysarthria are present), attention deficit

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disorder/attention deficit hyperactivity disorder, auditory conceptual dysfunction or conceptual handicap and severe global delay;

36. For all rehabilitative therapy, except as described in the *Certificate of Coverage*, including but not limited to play, music, and recreational therapy;
37. For sports medicine treatment or equipment which is intended primarily to enhance athletic performance;
38. For services or supplies that are considered by *Capital* to be *investigational*, except routine costs associated with *Approved Clinical Trials* that have been preauthorized by *Capital*. Routine costs do not include any of the following:
 - a. The *investigational* drug, biological product, device, medical treatment or procedure itself.
 - b. The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct *clinical management* of the patient.
 - c. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the *Approved Clinical Trial*.
 - d. *Member* travel expenses.
39. For all dental services rendered after stabilization of a *member* in an emergency following an accidental injury, including but not limited to, oral *surgery* for replacement teeth, oral prosthetic devices, bridges, or orthodontics;
40. For travel expenses incurred in conjunction with *benefits* unless specifically identified as a covered service elsewhere in this *Certificate of Coverage*;
41. For the following *mental health care/substance abuse* services: educational testing, evaluation testing, hypnosis, marital therapy, methadone maintenance, intellectual disability services, attention deficit disorder testing, other learning disability testing, and long-term care services provided in extended care and state mental health facilities;
42. For neuropsychological testing (NPT) when done through self-testing, self-scored inventories, and projective techniques testing or when done for educational purposes, screening purposes, patients with stable conditions, occupational exposure to toxic substances, or mental health diagnosis, including substance abuse;
43. For back-up or secondary durable medical equipment, including ventilators and prosthetic appliances, and for durable medical equipment requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home;
44. For replacement of lost or stolen durable medical equipment items, including prosthetic appliances, within the expected useful life of the originally purchased durable medical equipment or for continued repair of durable medical equipment after its useful life has exhausted;
45. For replacement of defective or non-functional durable medical equipment when the equipment is covered under the manufacturer's warranty;
46. For upgrade or replacement of durable medical equipment when the existing equipment is functional except when there is a change in the health of the *member* such that the current equipment no longer meets the *member's* medical needs;
47. For durable medical equipment intended for use in a facility (*hospital* grade equipment)

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48. For home delivery, education and set up charges associated with purchase or rental of durable medical equipment, as such charges are not separately reimbursable and are considered part of the rental or purchase price;
49. For prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device;
50. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, air purifiers and filters, physical fitness or exercise equipment, including, but not limited to inversion, tilt, or suspension device or table, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, diapers, deodorants, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a *provider*;
51. For items used as safety devices, and for elastic sleeves (except where otherwise required by law), thermometers, bandages, gauze, dressings, cotton balls, tape, adhesive removers, or alcohol pads;
52. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, including, but not limited to inversion, tilt, or suspension device or table, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, diapers, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a *provider*;
53. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;
54. For enteral nutrition due to lactose intolerance or other milk allergies;
55. For blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Certificate of Coverage*;
56. For all other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Certificate of Coverage*;
57. For immunizations required for travel or employment except as required by law;
58. For routine examination, testing, immunization, treatment and preparation of specialized reports solely for insurance, licensing, or employment including but not limited to pre-marital examinations, physicals for college, camp, sports or travel;
59. For services directly related to the care, filling, removal, or replacement of teeth; orthodontic care; treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth; or for dental implants, except where mandated by law and as specifically provided in this *Certificate of Coverage*;
60. For treatment of temporomandibular joint syndrome (TMJ) by any and all means including, but not limited to, *surgery*, intra-oral devices, splints, physical medicine, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ and except for treatment of TMJ caused by documented organic disease or physical trauma resulting from an accident; Intra-oral reversible prosthetic devices/appliances are excluded regardless of the cause of TMJ;
61. For *hearing aids*, examinations for the prescription or fitting of *hearing aids*, and all related services;
62. For eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to, refractive lenses prescribed for use with an intra-ocular lens transplant;

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63. For vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams; prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses;
64. For surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy and refractive keratoplasty;
65. For *infertility* services if the present condition of *infertility* is due, in part or in its entirety, to either party having undergone a voluntary sterilization procedure and/or an unsuccessful reversal of a voluntary sterilization procedure;
66. For donor services related to assisted fertilization;
67. For 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;
68. For routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except *surgery* for ingrown nails); corns, removal or reduction of warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints;
69. For supportive devices of the feet, unless otherwise mandated by law and when not an integral part of a leg brace. Supportive devices of the feet include foot supports, heel supports, shoe inserts, and all foot orthotics, whether custom fabricated or sold as is;
70. For treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury;
71. For treatment or procedures leading to or in connection with transsexual surgery or transgender reassignment surgery except for sickness or injury resulting from such surgery or for the surgical treatment of congenital ambiguous genitalia present at birth;
72. For all prescription and over-the-counter drugs dispensed by a pharmacy or *provider* for the *outpatient* use of a *member*, whether or not billed by a *facility provider*, except for allergy serums and mandated pharmacological agents used for controlling blood sugar and except where otherwise required by law;
73. For all prescription and over-the-counter drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan approved by *Capital*;
74. For treatment of obesity and/or morbid obesity, except for surgical treatment of morbid obesity when *medically necessary*;
75. For *inpatient* stays to bring about non-surgical weight reduction;
76. For private duty nursing services;
77. For biofeedback;
78. For acupuncture;
79. For autopsies or any other services rendered after a *member's* demise;

Schedule of Exclusions

80. For non-neonatal circumcisions, unless *medically necessary*;
81. For wigs and other items intended to replace hair loss due to male/female pattern baldness;
82. For all types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present;
83. For membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs, or replacement of devices, equipment or parts without charge or at a reduced charge;
84. For certain *Autism Spectrum Disorders* services, including manipulation therapy evaluation, myofascial and musculoskeletal treatment and/or manipulation; day treatment services, elimination diets, family based mental health services, host home services, nutritional supplements, rehabilitative therapy, including but not limited to play, music, and recreational therapy; residential treatment, and summer therapeutic activities program;
85. Except as required by law, for services that would otherwise be paid for by federal, state or local education related agencies, departments, schools or the like;
86. For services provided at unapproved sites, school settings, or as part of a *member's* education;
87. For any services related to or rendered in connection with a non-covered service, including but not limited to anesthesia, diagnostic services, etc.; and
88. For any other service or treatment except as provided in this *Certificate of Coverage*.

CLINICAL MANAGEMENT

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

Clinical Management Programs include:

- Utilization Management (*Preauthorization*, Medical Claims Review);
- Care Management (*Concurrent Review*, SmartSurgerysm Program, Discharge Outreach Call Program, *Case Management*);
- Disease Management;
- Maternity Management;
- Quality Management; and
- Health Education and Wellness (including 24-Hour Nurse Line and Nicotine Cessation Program).

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

UTILIZATION MANAGEMENT

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

Medical Necessity Review

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

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

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

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

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

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

A *member* or the *provider* may contact *Capital's* Clinical Management Department to determine whether a service is *medically necessary*.

Investigational Treatment Review

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

However, *Capital* recognizes that situations occur when a *member* elects to pursue *investigational* treatment at the *member's* own expense. If the *member* receives a service *Capital* considers to be *investigational*, the *member* is solely responsible for payment of these services and the non-covered amount will not be applied to the *out-of-pocket maximum* or *deductible*, if applicable.

A *member* or a *provider* may contact *Capital* to determine whether *Capital* considers a service to be *investigational*.

Preauthorization

Preauthorization is a process for evaluating requests for services prior to the delivery of care. The general purpose of the *preauthorization* program is to facilitate the receipt by *members* of:

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

Participating providers are responsible for obtaining required *preauthorizations*.

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

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

A *preauthorization* decision is generally issued within fifteen (15) business days of receiving all necessary information for non-urgent requests.

Medical Claims Review

Capital's clinicians conduct Medical Claims Review retrospectively through the review of medical records to determine whether the care and services provided and submitted for payment were *medically necessary*. Retrospective review is performed when *Capital* receives a claim for payment for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred:

- under *coverage* that does not include the *preauthorization* program;

- in situations such as an emergency when securing an authorization within required time frames is not practical or possible;
- for services that are potentially *investigational* or cosmetic in nature; or
- for services that have not complied with *preauthorization* requirements.

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

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

CARE MANAGEMENT

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

- *Concurrent Review* Program (including Discharge Planning);
- SmartSurgery Program;
- Discharge Outreach Call Program; and
- *Case Management* Program.

Concurrent Review Program

The *Concurrent Review* Program includes *concurrent review* and Discharge Planning.

Concurrent Review

Concurrent review is conducted by experienced *Capital* registered nurses and board-certified *physicians* to evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in *inpatient* settings (*acute care hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals*). In addition, the program is designed to facilitate identification and referral of *members* to other *Clinical Management* Programs, such as *Case Management* and Disease Management; to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning.

A *concurrent review* decision is generally issued within one (1) day of receiving all necessary information.

Discharge Planning

Discharge planning is performed by *concurrent review* nurses who communicate with *hospital* staff, either in person or by telephone, to facilitate the delivery of post-discharge care at the level most appropriate to the patient's condition. Discharge planning is also intended to promote the use of appropriate *outpatient* follow-up services to prevent avoidable complications and/or readmissions following *inpatient* confinement.

SmartSurgery Program

The SmartSurgery Program is for *members* scheduled to undergo selected elective surgical procedures. Prior to admission, a *Capital* nurse may contact a *member* by telephone to discuss expectations regarding the upcoming *hospital* stay, answer questions about scheduled procedures and address any other concerns regarding post-

discharge care. The goal of the program is to promote a successful *inpatient* stay and facilitate a smooth recovery by encouraging preoperative education, proper coordination of care, and early discharge planning.

Discharge Outreach Call Program

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

Case Management Program

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

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

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

DISEASE MANAGEMENT

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

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

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

MATERNITY MANAGEMENT PROGRAM

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

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

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

QUALITY MANAGEMENT PROGRAM

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

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

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

HEALTH EDUCATION AND WELLNESS PROGRAMS

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

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

24-Hour Nurse Line

The *Capital* 24-Hour Nurse Line staff of registered nurses are available to answer questions on health-related issues 24 hours a day, every day of the year. The service is designed to offer health and medical information, education and support. The service also offers assessment and advice, and suggests appropriate levels of care for symptomatic callers in the event *members* are unable to reach their *physician*. *Members* are encouraged to call

1-800-452-BLUE when they have the need for health information/education, or want assistance in determining how to best handle specific medical symptoms. Nurses are prepared to provide the following services:

- Answers to a *member's* questions on a health-related topic;
- Send information/educational materials as appropriate to the *member's* home; or
- Refer a *member* to an Audio Library for comprehensive information on a specific topic, disease or procedure.

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

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

Nicotine Cessation Program

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

- Nicotine Cessation Kit – kit, which is available for purchase by the *member*, includes a book and relaxation audio CD, along with other nicotine cessation related resources;
- Nurse Line - access 24 hours a day to a live nurse who can assist members with questions and resources focused on nicotine cessation;
- Discount Health Network - a network of local and regional community organizations who offer discounts on health-related services;
- Website links to credible organizations and programs focused on nicotine cessation; and
- References to available community programs.

Members also have access to counseling services provided by trained nicotine cessation counselors from the American Cancer Society. This counseling is provided in combination with nicotine replacement therapy (e.g. gum, patches) provided by *Capital's* vendor, subject to any applicable *cost-sharing amount* required of the *member*. No additional costs for the counseling services are incurred by the *member*.

HOW WE EVALUATE NEW TECHNOLOGY

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

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, *specialists* and professionals with expertise in the technology, and government agencies such as the Food and Drug Administration, the National Institutes of Health, and the Centers for Disease Control and Prevention. The five (5) key criteria used by the Committee to evaluate new technology are listed below:

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

After reviewing and discussing all of the available information and evaluating the new technology based on the criteria listed above, the Committee provides a recommendation to *Capital's* Corporate Policy Committee regarding the new technology and any necessary changes to medical policy. The Corporate Policy Committee makes final determinations concerning medical policy after assessing *provider* and *member* impacts of recommended policies.

Capital's medical policies are developed to assist us in administering *benefits* and do not constitute medical advice. Although the medical policies may assist *members* and their *provider* in making informed health care decisions, *members* and their treating *providers* are solely responsible for treatment decisions. *Benefits* for all services are subject to the terms of this *coverage*.

ALTERNATIVE TREATMENT PLANS

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

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

MEMBERSHIP STATUS

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

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

ELIGIBILITY

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

Non-Discrimination

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

Subscriber

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

Dependent - Spouse

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

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

Dependent –Domestic Partner

An individual must qualify as the *domestic partner* of the *subscriber* to enroll in this *coverage* as a *dependent domestic partner*.

Capital reserves the right to request documentation evidencing the *domestic partnership* by submission of proof of three (3) or more of the following documents:

- a domestic partnership agreement;
- a joint mortgage or lease;
- a designation of one of the partners as beneficiary in the other partner's will;
- a durable property and health care powers of attorney;

- a joint title to an automobile, or joint bank account or credit account; or
- such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

Child

To enroll under this coverage as a child, an individual must be under the age of twenty-six (26) and be:

- A birth child of the *subscriber*, the *subscriber's* spouse, or the *subscriber's domestic partner*;
- A child legally adopted by or placed for adoption with the *subscriber*, the *subscriber's* spouse, or the *subscriber's domestic partner*;
- A *ward* of the *subscriber*, the *subscriber's* spouse, or the *subscriber's domestic partner*; or
- A child for whom the *subscriber*, the *subscriber's* spouse, or the *subscriber's domestic partner* 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 under this *coverage* as a disabled *dependent* child. The child must be:

- A birth child, adopted child, or *ward* of the *subscriber*, the *subscriber's* spouse or the *subscriber's domestic partner*;
- Mentally or physically incapable of earning a living; and
- Chiefly dependent upon the *subscriber*, *subscriber's* spouse or the *subscriber's domestic partner* for support and maintenance, provided that:
 - ◇ The incapacity began before age twenty-six (26);
 - ◇ The *subscriber* provides *Capital* 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 *Capital*, but not more frequently than annually.

Extension of Eligibility for Students on Military Duty

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

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

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

In order to qualify for this extension of eligibility the child must submit the following forms to *Capital*:

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

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

ENROLLMENT

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

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

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*. However, *Capital* will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to sixty (60) days after the *member* is eligible for *coverage* under the *group contract* or as allowed by law. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to *Capital*.

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

Initial Enrollment

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

Newly Eligible Members

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

Subscriber

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

Dependent - Newborns

If the newborn child qualifies as a *dependent*, the *member* must notify the *contract holder* immediately and application must be made through the *contract holder* within the required timeframes to add the newborn child as a *dependent*.

Subscribers should consult with the *contract holder* to determine the timeframes applicable to enrolling a newborn as a *dependent*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section of this *Certificate of Coverage* for more details.

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

Life Status Change

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

- A change in job status;
- A change in marital status;
- A change in *domestic partnership*;
- The birth, adoption, or placement for adoption of a child;
- Acquiring a stepchild or becoming a legal guardian for a child;
- A court order;
- A change in *Medicare* status;
- A change in the status of other insurance; or
- Loss of other minimum essential coverage, including but not limited to, a loss due to termination of employment or reduction in hours, divorce or legal separation, relocation outside *Capital's service area*, or a child ceasing to be eligible for coverage under the *group contract*.

If one of these events occurs, the member must notify the *contract holder* immediately. To enroll with *Capital* for coverage, *members* must enroll within the required timeframe after one of the following, as applicable:

- The date of marriage, existence of a *domestic partnership*, birth, adoption or placement for adoption, or in the case of a *ward*, the date specified in the legal custody order; or

- The date of the loss of the other health insurance coverage.

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

Group Enrollment Period

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

EFFECTIVE DATE OF COVERAGE

Initial and Newly Eligible Members

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

Life Status

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

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

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

TERMINATION OF COVERAGE

TERMINATION OF GROUP CONTRACT

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

TERMINATION OF COVERAGE FOR MEMBERS

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

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

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

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

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

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

Termination of Coverage

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

CONTINUATION OF COVERAGE AFTER TERMINATION

COBRA COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a Federal law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage* with *Capital*.

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

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

ELIGIBILITY FOR CONVERSION COVERAGE

A *member* whose *coverage* is about to terminate may be eligible to convert to an individual contract available from the Capital BlueCross family of companies. Separate and apart from this conversion right, a *member* whose *coverage* terminates may be eligible for enrollment in individual products on or off the *Marketplace*.

Examples of situations in which a *member* may be offered this conversion privilege include, but are not limited to:

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

Examples of situations in which a *member* will NOT be offered this conversion privilege include, but are not limited to:

- The *contract holder* cancelled this *coverage* with *Capital* for coverage with another carrier;
- The *member* failed to pay any required contribution or premium to the *contract holder* and, as a result, the *contract holder* terminated the *member's coverage*;
- The *member* is eligible to enroll in Part A or Part B of *Medicare*;
- The *member* is enrolled in other coverage which, together with the benefits provided under a conversion policy from the Capital BlueCross family of companies, would result in overinsurance if such overinsurance standards are on file with the Pennsylvania Insurance Department; or
- The *member* is provided similar medical coverage under any state or Federal law.

Coverage under the individual conversion contract begins the day after termination of this *coverage*, subject to receipt of premium payments. *Capital* is not liable for the cost of *benefits* provided to *members* after the date of termination if they do not exercise the conversion privilege as specified herein.

Notification of conversion is sent to the *subscriber*. This notice contains information on the conversion options as well as applications for coverage. Written application for a conversion contract must be made to *Capital* no later than:

- Thirty-one (31) days after termination of coverage under this *coverage*; or

Continuation of Coverage After Termination

- Thirty-one (31) days after the *member* has been given written notice of the existence of the conversion privilege.

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

APPLYING FOR CONVERSION COVERAGE IS THE *MEMBER'S* RESPONSIBILITY.

COVERAGE FOR MEDICARE-ELIGIBLE MEMBERS

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

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

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

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.

If an eligible *member* meets the definition of *totally disabled*, extended disability *benefits* are provided:

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

whichever occurs first.

A *member* must contact *Capital's* Customer Service Department to start the application process for coverage under this provision.

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

CLAIMS REIMBURSEMENT

CLAIMS AND HOW THEY WORK

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

Participating Providers

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

Non-Participating Providers

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

Out-of-Area Providers

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

ALLOWABLE AMOUNT

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

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

FILING A CLAIM

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

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

Claims Reimbursement

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

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

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

Members must also provide the following information, if applicable:

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

Claims Reimbursement

8. Blood – number of units received, charge for each unit, and number of units replaced by donor(s).
9. Chemotherapy – name of drug, dosage of drug, charge for each drug, and the method of administration (oral, intra-muscular injections, intravenous, etc.)
10. Durable medical equipment certification from the doctor concerning the *medical necessity* and expected length of time equipment will be needed. If renting equipment, *members* should have the durable medical supplier provide the equipment purchase price.

A Special Note About Medical Records

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

Where to Submit Medical Claims

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

Capital BlueCross
PO Box 211457
Eagan, MN 55121

Members who need help submitting a medical claim can contact Customer Service at **1-800-962-2242** (TTY: **711**).

OUT-OF-COUNTRY CLAIMS

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

Inpatient Hospital Claims

Claims for *inpatient hospital* services arranged through the BlueCard Worldwide Service Center require *members* to pay only the usual *cost-sharing amounts*. The *hospital* files the claim for the *member*. *Members* who receive *inpatient hospital* care from a *non-participating hospital* or services that were not coordinated through the BlueCard Worldwide Service Center may have to pay the *hospital* and submit the claim to the BlueCard Worldwide Service Center at P.O. Box 72017, Richmond, VA 23255-2017.

Professional Provider Claims

For all *outpatient* and professional medical care, the *member* pays the *provider* and then submits the claim to the BlueCard Worldwide Service Center at P.O. Box 72017, Richmond, VA 23255-2017. The claim should be submitted showing the currency used to pay for the services.

International Claim Form

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

CLAIM FILING AND PROCESSING TIME FRAMES

Time Frames for Submitting Claims

All claims must be submitted within twelve (12) months from the date of service with the exception of claims from certain State and Federal agencies.

Time Frames Applicable to Medical Claims

If the *member's* claim involves a medical service or supply that was already received, *Capital* will process the claim within thirty (30) days of receiving the claim. *Capital* may extend the thirty (30)-day time period one (1) time for up to fifteen (15) days for circumstances beyond *Capital's* control. *Capital* will notify the *member* prior to the expiration of the original time period if an extension is needed. The *member* and *Capital* may also agree to an extension if the *member* or *Capital* requires additional time to obtain information needed to process the claim.

Special Time Frames Applicable to “Concurrent Care” Claims

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

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

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

COORDINATION OF BENEFITS (COB)

The coordination of *benefits* provision of this *Certificate of Coverage* applies when a person has health care coverage under more than one Plan as defined below.

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

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

Definitions Unique to Coordination of Benefits

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

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

Claims Reimbursement

Other Plan: Other Plan means any individual coverage or group arrangement providing health care benefits or services through:

1. individual, group, blanket or franchise insurance coverage except that it shall not mean any blanket student accident coverage or hospital indemnity plan of one hundred (\$100) dollars or less;
2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage;
3. coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. coverage under any tax-supported or any government program to the extent permitted by law.

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

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

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when the *member* has health care coverage under more than one Plan.

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

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

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

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

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

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

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

Allowable Expense: Allowable expense is a health care expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering the *member*. When a Plan provides benefits in

Claims Reimbursement

the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the *member* is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an Allowable Expense.

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

- The difference between the cost of a semi-private *hospital* room and a private *hospital* room, unless one of the Plans provides coverage for private *hospital* room expenses.
- Any amount in excess of the highest reimbursement amount for a specific benefit when two (2) or more Plans that calculate benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the *member*.
- Any amount in excess of the highest of the negotiated fees when two (2) or more Plans that provide benefits or services on the basis of negotiated fees cover the *member*.
- If the *member* is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology covers a person and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the *provider* has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
- The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, *preauthorization*, and preferred provider arrangements.

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

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

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

Order of Benefit Determination Rules

When a *member* is covered by two (2) or more Plans, the rules for determining the order of benefit payments are as follows:

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

Claims Reimbursement

4. Each Plan determines its order of *benefits* using the first of the following rules that apply:

a. Non-Dependent or Dependent.

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

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

b. Child Covered Under More Than One Plan.

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

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

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

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

- If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the child's health care expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:
 - ◇ The Plan covering the Custodial Parent;
 - ◇ The Plan covering the spouse of the Custodial Parent;
 - ◇ The Plan covering the non-custodial parent; and then
 - ◇ The Plan covering the spouse of the non-custodial 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 health care coverage. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

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

Right to Receive and Release Needed Information

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

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

Facility of Payment

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

Right of Recovery

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

COORDINATION OF BENEFITS WITH MEDICARE

Active Employees and Spouses Age 65 and Older

If a *subscriber* (or his/her spouse), age sixty-five (65) or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that did not employ twenty (20) or more employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, then *Medicare* shall be primary for the *subscriber* or spouse. The *benefits* of the *group contract* will then be the secondary form of coverage.

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

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

Disability

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

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

End Stage Renal Disease (ESRD)

The *group contract* will remain primary for the first thirty (30) months of a *member's* eligibility or entitlement to *Medicare* due to End Stage Renal Disease (as defined under applicable *Medicare* statutes). However, if the *group contract* is currently paying *benefits* as secondary to *Medicare* for a *member*, the *group contract* will remain secondary upon a *member's* entitlement to *Medicare* due to ESRD.

Retirees

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

THIRD PARTY LIABILITY/SUBROGATION

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

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in the *contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

Claims Reimbursement

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections of this *Certificate of Coverage*.

ASSIGNMENT OF BENEFITS

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

PAYMENTS MADE IN ERROR

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

APPEAL PROCEDURES

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

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

Members who disagree with an *adverse benefit determination* with respect to *benefits* available under this *coverage* may seek review of the *adverse benefit determination* by submitting a written appeal within 180 days of receipt of the *adverse benefit determination*.

For more information, *members* should refer to the **How to File an Appeal** attachment included with this *Certificate of Coverage*.

Members can call Customer Service at **1-800-962-2242** if they have questions on this attachment or if they would like another copy of the attachment.

MEMBER RIGHTS AND RESPONSIBILITIES

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

MEMBER RIGHTS

Members have a right:

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

Member Rights and Responsibility

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

MEMBER RESPONSIBILITIES

Members have a responsibility:

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

GENERAL PROVISIONS

ADDITIONAL SERVICES

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

Capital may also make available to its *members* access to health education and wellness related programs offered through contracted companies. Participation in these programs is optional to each *member*. These programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by *Capital* separately or independently from the *group contract*. There is no additional charge to *members* for accessing these programs. Contact the Plan Administrator for information on these programs.

BENEFITS ARE NON-TRANSFERABLE

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

CHANGES

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

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

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

Capital will provide the *contract holder* with an *official notice of change* at least 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 *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 thirty (30) 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.

CHANGES IN LAW

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 participating or non-participating in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular health care *provider*. If the *member's participating provider* ceases participation, *Capital* will provide access to other *providers* with similar training and experience.

CLERICAL ERROR

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

ENTIRE AGREEMENT

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

EXHAUST ADMINISTRATIVE REMEDIES FIRST

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

FAILURE TO ENFORCE

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

FAILURE TO PERFORM DUE TO ACTS BEYOND CAPITAL’S CONTROL

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

GENDER

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

IDENTIFICATION CARDS

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

Identification cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *identification cards* must be returned to *Capital* within thirty-one (31) days of the *member's* termination. *Identification cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

LEGAL ACTION

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

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

LEGAL NOTICES

Any and all legal notices under the *group contract* shall be given in writing and by the United States mail, postage prepaid, 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 provided by the *contract holder* to *Capital*.
- If to *Capital*: to Legal Department, 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 *participating providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

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

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

PAYMENT RECOUPMENT

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

POLICIES AND PROCEDURES

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

RELATIONSHIP OF PARTIES

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

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

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

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital BlueCross, or Keystone Health Plan Central.

WAIVER OF LIABILITY

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether a *participating provider* or *non-participating 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.

ADDITIONAL INFORMATION

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

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

Requests must specifically identify what information is being requested and should be sent to:

Capital BlueCross
PO Box 779519
Harrisburg, PA 17177-9519

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

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

DEFINITIONS

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

Adverse Benefit Determination: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit*, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a *member's* eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit* resulting from the application of any utilization review, as well as a failure to cover an item or service for which *benefits* are otherwise provided because it is determined to be *investigational* or not *medically necessary*.

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

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

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

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

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

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or other life threatening disease or condition and is described below:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 1. The National Institutes of Health (NIH)
 2. Centers for Disease Control and Prevention (CDC)
 3. Agency for Healthcare Research and Quality (AHRQ)
 4. Centers for Medicare and Medicaid Services (CMS)
 5. 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 non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
 - The study or investigation is a drug that is exempt from having such an investigational new drug application.

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

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

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

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

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

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

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

Birthing Facility: A *facility provider* licensed and approved by the appropriate governmental agency, which is primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Domestic Partner: Shall mean a member of a *domestic partnership* consisting of two (2) partners, each of whom meet the requirements of a *domestic partnership*.

Domestic Partnership: Shall mean a partnership consisting of a *subscriber* and a *domestic partner* each of whom:

- is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- is not related to the other partner by adoption or blood;

- is the sole *domestic partner* of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this *domestic partnership* for the last six (6) months;
- agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships; and
- demonstrates financial interdependence by submission of proof of three (3) or more of the following documents: (a) a domestic partnership agreement; (b) a joint mortgage or lease; (c) a designation of one of the partners as beneficiary in the other partner's will; (d) a durable property and health care powers of attorney; (e) a joint title to an automobile, or joint bank account or credit account; or (f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case. *Capital* reserves the right to request documentation of any of the foregoing prior to commencing *coverage* for the *domestic partner*.

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

Emergency Service: Any health care services provided to a *member* after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

Facility Provider: Facility *providers* include:

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

- *Hospice*
- *Hospital*
- *Hospital Laboratories*
- *Infusion Therapy Provider*
- *Long-Term Acute Care Hospital*
- *Orthotics Supplier*
- *Prosthetics Supplier*
- *Psychiatric Hospital*
- *Rehabilitation Hospital*
- *Skilled Nursing Facility*
- *Substance Abuse Treatment Facility*
- *Urgent Care Center*

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

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

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

Freestanding Outpatient Facility: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing *outpatient* diagnostic and/or therapeutic services by or under the supervision of *physicians*.

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

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

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

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

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

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

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

Home Health Care Agency: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, which provides skilled nursing and other services on an intermittent basis in the *member's* home; and is responsible for supervising the delivery of such services under a plan prescribed by the attending *physician*.

Hospice: A *facility provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing palliative care to terminally ill *members* and their families with such services being centrally coordinated through an interdisciplinary team directed by a *physician*.

Hospital: A *facility provider* that:

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

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

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

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

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

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

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

Inpatient: A *member* who is admitted as a patient and spends greater than 23 hours in a *hospital*, a *rehabilitation hospital*, a *skilled nursing facility* or a non-residential *substance abuse treatment facility* and for whom a room and board charge is made. This term may also describe the services rendered to such a *member*. The term *inpatient* does not apply to a *member* who is admitted to a *substance abuse treatment facility* for non-*hospital* residential services.

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

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

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

- the *member’s* medical records;
- the protocol(s) pursuant to which the treatment or procedure is to be delivered;
- any consent document the patient has signed or will be asked to sign, in order to undergo the treatment or procedure;
- the referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- regulations and other official actions and publications issued by the federal government; and
- the opinion of a third party medical expert in the field, obtained by *Capital*, with respect to whether a treatment or procedure is investigational.

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

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

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

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

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

Medical Necessity (Medically Necessary): Shall mean:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participating Provider(s): A *professional provider*, *facility provider*, or any other eligible health care *provider* or practitioner that is approved by *Capital* and, where licensure is required, is licensed in the applicable state and provides covered services and has entered into a *provider* agreement with or is otherwise engaged by *Capital* to provide *benefits* to *members* and who satisfies *Capital's* credentialing and privileging criteria. The status of a *provider* as a participating *provider* may change from time to time. It is the *member's* responsibility to verify the current status of a *provider*.

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

Pervasive Developmental Disorders: Are conditions characterized by severe and pervasive impairment in several areas of development:

- Reciprocal social interaction skills;
- Communication skills; or
- Presence of stereotyped behavior, interests, and activities.

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

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulations, each as amended.

Preauthorization: An authorization (or approval) from *Capital* or its designee which results from a process utilized to determine *member* eligibility at the time of request, *benefit* coverage and *medical necessity* of proposed

medical services prior to delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this *Certificate of Coverage*.

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

Professional Provider: Professional *providers* include:

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

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

Psychiatric Hospital: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing diagnostic and therapeutic services for the *mental health care*. Such services are provided by or under the supervision of an organized staff of *physicians*.

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

Reconstructive Surgery: A procedure performed to improve or correct a *functional impairment*, restore a bodily function or correct deformity resulting from *birth defect* or accidental injury. The fact that a *member* might suffer

psychological consequences from a deformity does not, in the absence of bodily *functional impairment*, qualify *surgery* as being reconstructive surgery.

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

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

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

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

- Covered Services under this *Certificate of Coverage* that would typically be provided absent an *Approved Clinical Trial*.
- Services and supplies required solely for the provision of the *Investigational* drug, biological product, device, medical treatment or procedure.
- The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.
- The services and supplies required for the diagnosis or treatment of complications.

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

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

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

- minimal care, *custodial care*, ambulatory care, or part-time care services; or
- care or treatment of *mental illness* or *substance abuse*.

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

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

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

Substance Abuse: The use of alcohol and/or other addictive drugs which produce a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Drugs are defined as addictive drugs and drugs of abuse listed as scheduled drugs in the Pennsylvania Controlled Substances, Drug, Device and Cosmetic Act.

Substance Abuse Treatment Facility: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital* and which primarily provides non-residential detoxification and/or rehabilitation treatment for *substance abuse*. This facility must also meet all applicable standards set by the state in which health care services are received.

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

Totally Disabled (or Total Disability): A condition resulting from disease or injury in which, as determined by *Capital's* Medical Director:

- 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; or
- 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.

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.

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

This information highlights the preventive care services available under this coverage. It is not intended to be a complete list or complete description of available services. Services may be subject to copayment, deductible and/or coinsurance. Additional diagnostic studies may be covered if medically necessary for a particular diagnosis or procedure. 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.

SERVICE	RECOMMENDED AGES/FREQUENCY *
<p>Routine History and Physical Examination – Initial/Interval Exams should include:</p> <ul style="list-style-type: none"> Newborn screening (including gonorrhea prophylactic topical eye medication and hearing loss) Head circumference (up to 24 months) Height/length and weight Body mass index (BMI; beginning at 2 years of age) Blood pressure (beginning at 3 years of age) Sensory screening for vision and hearing Developmental milestones (screening/surveillance) Iron supplementation (6 to 12 months) at increased risk for iron deficiency anemia*** Autism screening (18 + 24 months) STD screening (males/females, as appropriate) Anticipatory guidance for age-appropriate issues including: <ul style="list-style-type: none"> Growth and development, breastfeeding/nutrition, obesity prevention, physical activity and psychosocial/behavioral health Safety, unintentional injuries, firearms, poisoning, media access Pregnancy prevention Tobacco products Dental care/fluoride supplementation (≥ 6 months)³ Fluoride varnish painting of primary teeth (to age 5 years) Sun/UV radiation skin exposure 	<p>Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years to 18 years annually</p>
SCREENINGS	RECOMMENDED AGES/FREQUENCY **
Newborn screen (including hypothyroidism, sickle cell disease and PKU)	At birth
Lead screening	9-12 months (at risk) ¹
Hemoglobin and Hematocrit	At 12 months: routine one-time testing Assess risk at all other well child visits
Urinalysis	5 years (at risk)
Lipid screening (risk assessment)	Every 2 years, starting at 2 years -- 2, 4, 6, 8 and 10 years Annually, starting at 11 years
Fasting Lipid Profile	Routinely, at 18 years (younger if risk assessed as high)
Tuberculin test	Assess risk at every well child visit
Vision test (objective method)	Beginning at 3 years: annually
Hearing test (objective method)	At birth and at 4, 5, 6, 8 and 10 years
Depression screening (PHQ-2)	Beginning at 11 years: annually
Alcohol and drug use assessment (CRAFFT)	Beginning at 11 years: annually
STI/HIV screening	Beginning at 11 years: annually
Syphilis test (males/females)	18 years and younger (high risk males/females***): suggested testing interval is 1-3 years
HIV test (males/females)	Age 15-18: routine one-time testing Regardless of age: repeat testing of all high risk persons;*** suggested testing interval is 1-5 years
Chlamydia test (females)	18 years and younger (sexually active females as well as other asymptomatic females at increased risk*** for infection): annually
Gonorrhea test (females)	18 years and younger (high risk sexually active females***): suggested testing interval is 1-3 years.
IMMUNIZATIONS	RECOMMENDED AGES/FREQUENCY **
Rotavirus (RV)	2 months, 4 months, or 6 months for specific vaccines
Polio (IPV)	2 months, 4 months, 6-18 months, 4-6 years
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15-18 months, 4-6 years
Tetanus/reduced Diphtheria/Pertussis (Tdap)	11-12 years (catch-up through age 18)
Human papillomavirus (HPV2/HPV4 -- females); (HPV4 -- males)	11--12 years (3 doses) (catch-up through age 18)
Measles/Mumps/Rubella (MMR)	12-15 months, 4-6 years (catch-up through age 18)
Hemophilus influenza type b (Hib)	2 months, 4 months, 6 months for specific vaccines & 12-15 months
Varicella/Chickenpox (VAR)	12-15 months, 4-6 years (catch-up through age 18)
Hepatitis A (HepA)	12-23 months (2 doses) (catch-up through age 18)
Influenza	6 months-18 years; annually ² during flu season
Pneumococcal conjugate (PCV13)	2 months, 4 months, 6 months, 12-15 months
Pneumococcal polysaccharide (PPSV23)	2-18 years (1 or 2 doses) [high risk: see CDC]
Hepatitis B (HepB)	Birth, 1-2 months, 6-18 months (catch-up through age 18)
Meningococcal (MenACWY-D/MenACWY-CRM) [high risk: see CDC]	11-12 years, 16 years (catch-up through age 18)

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This preventive schedule is periodically updated to reflect current recommendations from the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention (CDC) [www.cdc.gov].

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

*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.

**Capital BlueCross considers Members to be “high risk” or “at risk” in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC).

***Capital BlueCross considers individuals to be “high risk” or “at risk” in accordance with the recommendations set forth by the U.S. Preventive Services Task Force (USPSTF)[www.ahrq.gov/clinic/uspstfix.htm]

Screening/Immunizations footnotes:

¹ Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.

² Children aged 8 years and younger who are receiving influenza vaccines for the first time should receive 2 separate doses, both of which are covered. Household contacts and out-of-home caregivers of a high risk Member, including a child aged 0-59 months, should be immunized against influenza.

³ Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.

This information highlights the preventive care services available under this coverage. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment, deductible and/or coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. *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.

SERVICE	RECOMMENDED AGES/FREQUENCY *
Routine History and Physical Examination, including BMI and pertinent patient education <i>Adult counseling and patient education include:</i>	WOMEN --19+: at least annually
Women	MEN--19-29: once 30-49: every 4 years 50+: annually
Folic Acid (childbearing age) HRT (risk vs. benefits)	
Contraceptive methods/counseling Breast Cancer chemoprevention (high risk)***	
Mammography screening Breastfeeding support/counseling/supplies	
Men	
Prostate Cancer screening	
For Both	
Tobacco use Physical Activity Depression	
STIs Drug and Alcohol use Calcium/vitamin D intake	
Seat Belt use Unintentional Injuries Fall Prevention	
Aspirin prophylaxis Family Planning Domestic/Interpersonal	
(high risk) *** Sun/UV skin radiation Violence	
SCREENINGS	RECOMMENDED AGES/FREQUENCY**
Obesity/Healthy diet screening/counseling	Age 19 and older (high risk);*** every year
Pelvic Exam/Pap Smear [USPSTF cytology option] ⁵	Age 21-29; every 3 years
Pelvic Exam/Pap Smear [USPSTF cytology option] ⁵	Age 30-65; every 3 years
Pelvic Exam/Pap Smear/HPV DNA [USPSTF co-testing option] ⁵	Age 30-65; every 5 years
Pelvic Exam/HPV DNA (women) [IOM option] ⁵	Beginning at 30; every 3 years
Chlamydia Test (women)	Age 19-24: Test all sexually active females; annually Age 25 and older: Test all females at increased risk; *** suggested testing interval is 1-3 years
Gonorrhea Test (women)	Age 19 and older: Test all high risk sexually active females;*** suggested testing interval is 1-3 years.
Syphilis Test (men/women)	Age 19 and older: Test all high risk men/women; *** suggested testing interval is 1-3 years
HIV Test (men/women)	Age 19-65: Routine one-time testing of persons not known to be at increased risk for HIV infection Age 19 and older: Repeat testing all high risk persons; *** suggested testing interval is 1-5 years
Hepatitis C Test	Offer one-time testing of adults born between 1945 and 1965 Periodic testing of persons with <i>continued high risk</i> *** for HCV infection
Blood Pressure	Age 19 and older: every 2 years (general ≥ 60 : < 150/90; general < 60 and all others: < 140/90)
Diabetes Screening Test (type 2)	Beginning at 19; test asymptomatic adults with sustained BP > 135/80 every 3 years
Fasting Lipid Profile	Beginning at 20; every 5 years
Fecal Occult Blood Test ¹	Beginning at 50; annually
Flexible Sigmoidoscopy ²	Beginning at 50; every 5 years
Colonoscopy ²	Beginning at 50; every 10 years
Barium Enema X-ray ³	Beginning at 50; every 5 years
Prostate Specific Antigen	Offer beginning at 50 and annually thereafter
Low-dose CT Scan	Age 55-80 (high risk): *** Annual testing until smoke-free for 15 years.
Abdominal Ultrasound (men)	Age 65-75: one-time screening for abdominal aortic aneurysm in men who have ever smoked
BRCA screening/counseling/testing [as needed]	Beginning at 19 (high risk women); *** reassess screening every 5-10 years
Mammogram	Beginning at 40; every 1-2 years
Bone Mineral Density (BMD) Testing (women)	Age 19-64: testing every 2 years may be appropriate for women at high risk. *** Beginning at 65; every 2 years
IMMUNIZATIONS	RECOMMENDED AGES/FREQUENCY**
Tetanus/diphtheria/pertussis (Td/Tdap)	19+; Td every 10 years (substitute one dose of Tdap for Td, regardless of interval since last booster)
Human papillomavirus (HPV2/HPV4 -- women); (HPV4 -- men)	19-26; three doses, if not previously immunized (for men 22-26, see CDC)
Hepatitis A (HepA)	19+; two doses (high risk; see CDC)
Hepatitis B (HepB)	19+; three doses (high risk; see CDC)
Hemophilus influenza type b (Hib)	19+; one or three doses (high risk; see CDC)
Influenza ⁴	19+; one dose annually during influenza season
Meningococcal (MCV4/MPSV4)	19+; one or more doses: (college students and others at high risk not previously immunized; see CDC)
Pneumococcal (conjugate) (PCV13)	19+; one dose (high risk; see CDC)
Pneumococcal (polysaccharide) (PPSV23)	19-64; one or two doses (high risk; see CDC) Beginning at 65; one dose (regardless of previous PPSV23 immunization; see CDC)
Measles/Mumps/Rubella (MMR)	19-54; one or two doses, give as necessary based upon past immunization history 55+; one or two doses (high risk; see CDC)
Varicella (Chickenpox)	Beginning at 19; two doses, give as necessary based upon past immunization or medical history
Zoster (Shingles)	Beginning at 50; one dose, regardless of prior zoster episodes (see CDC)

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This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); 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); Institute of Medicine (IOM); U.S. Food and Drug Administration (FDA).

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

* 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. Occupational, school and other “administrative” exams are not covered.

**Capital BlueCross considers individuals to be “high risk” or “at risk” in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC) [www.cdc.gov]

***Capital BlueCross considers individuals to be “high risk” or “at risk” in accordance with the recommendations set forth by the U.S. Preventive Services Task Force USPSTF [www.ahrq.gov/clinic/uspstfix.htm]

Screenings/Immunizations footnotes:

¹For guaiac-based testing, six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing, specific manufacturer’s instructions are followed.

²Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

³Barium enema is listed as an alternative to a flexible sigmoidoscopy, with the same schedule overlap prohibition as found in footnote #2.

⁴Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

⁵Recommendations of both the USPSTF and the IOM are included in order to aid clinicians in counseling their patients about preferred or acceptable preventive strategies. It should be noted that screening for cervical cancer should not be the sole health care concern when conducting ongoing well-woman visits.

SERVICES REQUIRING PREAUTHORIZATION

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

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

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

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

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

PREAUTHORIZATION PENALTY APPLICABILITY

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* Certificate of Coverage. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

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

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

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

Category	Details	Comments
Inpatient Admissions	<ul style="list-style-type: none"> • Observation care admissions • Acute care • Long-term acute care • Non-routine maternity admissions • Skilled nursing facilities • Rehabilitation hospitals • Behavioral Health (mental health care/ substance abuse) includes partial hospitalization & intensive outpatient programs 	<p>Emergent/Urgent admissions to observation or inpatient status require notification within two (2) business days. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify Capital BlueCross of an admission may result in an administrative denial.</p> <p>Non-routine maternity admissions require notification within two (2) business days of the date of admission.</p> <p><i>Preauthorization</i> requirements do not apply to services provided by a <i>hospital</i> emergency room <i>provider</i>. If an <i>inpatient</i> admission or observation admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the <i>hospital</i> is a <i>participating provider</i>, the <i>hospital</i> is responsible for performing the notification. If the <i>hospital</i> is a <i>non-participating provider and is not BlueCard</i>, the <i>member</i> or the <i>member's</i> responsible party acting on the <i>member's</i> behalf is responsible for the notification</p>
Diagnostic Services	<ul style="list-style-type: none"> • Genetic disorder testing except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing • 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 • SPECT (single proton emission computerized tomography) scans 	<p>Diagnostic services do not require <i>preauthorization</i> when emergently performed during an emergency room visit, observation stay, or <i>inpatient</i> admission.</p>
Durable Medical Equipment (DME), Prosthetic Appliances & Orthotic Devices	<p>Purchases and Repairs greater than or equal to \$500 Rentals for DME regardless of price per unit</p>	
Office Surgical Procedures When Performed in a Facility*	<ul style="list-style-type: none"> • 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 facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals 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) 	<p>The items listed are those items or services most frequently requested. This list is not all inclusive.</p> <p>Depending on whether the <i>provider</i> is participating or non-participating, <i>members</i> or their <i>provider</i> must contact <i>Capital</i> to confirm if items or services not listed here require <i>preauthorization</i>.</p>
Outpatient Surgery for Select Procedures	<ul style="list-style-type: none"> • Weight loss surgery (Bariatric) • Implantation electrical nerve stimulator • 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 	<p>The items listed are those items or services most frequently requested. This list is not all inclusive.</p> <p>Depending on whether the <i>provider</i> is participating or non-participating, <i>members</i> or their <i>provider</i> must contact <i>Capital</i> to confirm if items or services not listed here require <i>preauthorization</i>.</p>

Category	Details	Comments
Therapy Services	<ul style="list-style-type: none"> Hyperbaric oxygen therapy (non-emergency) Manipulation therapy (chiropractic and osteopathic) Occupational therapy Physical therapy Pulmonary rehabilitation programs Respiratory Therapy 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) 	
Reconstructive or Cosmetic Services and Items	<p>Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy)</p> <p>Breast Procedures</p> <ul style="list-style-type: none"> Breast Enhancement (Augmentation) Breast Reduction Mastectomy (Breast removal or reduction) for Gynecomastia Breast Lift (Mastopexy) Removal of Breast implants <p>Correction of protruding ears (Otoplasty)</p> <p>Repair of nasal/septal defects (Rhinoplasty/Septoplasty)</p> <p>Skin related procedures</p> <ul style="list-style-type: none"> Acne surgery Dermabrasion Destruction of premalignant skin cells Hair removal (Electrolysis/Epilation) Face Lift (Rhytidectomy) Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) Mohs Surgery <p>Treatment of Varicose Veins and Venous Insufficiency</p>	<p>The items listed are those items or services most frequently requested. This list is not all inclusive.</p> <p>Depending on whether the <i>provider</i> is participating or non-participating, <i>members</i> or their <i>provider</i> must contact <i>Capital</i> to confirm if items or services not listed here require <i>preauthorization</i>.</p>
Transplant Surgeries	Evaluation and services related to transplants	<i>Preauthorization</i> will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.
Other Services	<ul style="list-style-type: none"> 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 Home infusion therapy 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 Specialty medical injectable medications Enteral feeding supplies and services. 	

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at 1-800-962-2242 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

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

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

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

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

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

- ▶ Pediatric Asthma
- ▶ Pediatric Diabetes

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

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

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

TO APPEAL AN ADVERSE BENEFIT DETERMINATION

An *adverse benefit determination* is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit*, including any such denial, reduction, termination of, or a failure to provide or make payment that is based on a determination of a *member's* eligibility to participate under the *group contract*; and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit* resulting from the application of any utilization review, as well as a failure to cover an item or service for which *benefits* are otherwise provided because it is determined to be *experimental or investigational* or not *medically necessary*.

For initial appeals dealing with eligibility determinations, terminations, and rescissions as defined under Patient Protection and Affordable Care Act, please contact your plan administrator for the applicable appeal procedures.

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

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

The *member* may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, *Capital* will provide the *member* with a full and fair internal review. The *member* may contact *Capital* at 1-800-962-2242 (TTY: 711) to receive information on the internal review process and to receive additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which *Capital* relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al 1-800-962-2242.* *Capital* will provide the *member* with a determination within thirty (30) days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within sixty (60) days for an appeal of an adverse benefit determination for a postservice claim (where services or supplies have already been received). If *Capital's* determination is still adverse to the *member* in whole or in part, the *member* will receive a Final Internal Adverse Benefit Determination.

External Appeal Process: A *member* may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination pertaining to *medical necessity*.

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

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

Members of a group health plan subject to ERISA may have a right to bring a civil action under Section 502(a) of ERISA.

EXPEDITED APPEAL PROCESS FOR CLAIMS INVOLVING URGENT CARE

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

Initial Determination for Claims Involving Urgent Care. *Capital* will notify the member of a determination, whether adverse or not, regarding a claim involving urgent care within seventy-two (72) hours of receipt of the claim. For this purpose a claim involving urgent care is a claim for medical care or treatment for which the application of the time periods for making non urgent care determinations could seriously jeopardize the life or health of the *member* or jeopardize his or her ability to regain maximum function or, in the opinion of a physician with knowledge of the *member's* medical condition, would subject the *member* to severe pain that cannot be adequately managed without the care and treatment that is the subject of the claim.

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

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

HOW TO APPEAL A CONCURRENT CARE CLAIM DETERMINATION

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

If *Capital* approved an ongoing course of treatment to be provided over a period of time or number of treatments, the *member* has the right to an expedited appeal of any reduction or termination of that course of treatment by *Capital* before the end of such previously approved period of time or number of treatments. *Capital* will notify the *member* of its decision to reduce or terminate the *member's* course of treatment at a time sufficiently in advance of the reduction or termination to allow the *member* to appeal and obtain an appeal decision before the *member's* benefits are reduced or terminated.

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

DESIGNATING AN INDIVIDUAL TO ACT ON YOUR BEHALF

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

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

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

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

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

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

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Applicable Group Numbers

00504099 PPO Plan 3

January, 2015