Capital BLUE

Capital BlueCross is an Independent Licensee
of the BlueCross BlueShield Association

Rx CARD PLAN
FOR PRESCRIPTION DRUG BENEFITS

CERTIFICATE OF COVERAGE

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

Table of Contents

Table of Contents

WELCOME

INTRODUCTION

Thank you for choosing *prescription drug 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 *Dental*^{sm}) and Vision (BlueCross *Vision*^{sm}) 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 is the following attachment to this *Certificate of Coverage*, which is applicable to this *coverage*:

- **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 prescription drug* expenses may not be covered. *Members* should read this *Certificate of Coverage* carefully to determine which *prescription drugs* and services are provided as *benefits* under their *coverage*.
- To have *benefits* paid at the highest allowable level, the *member's coverage* may require *prescription drugs* and related services to be provided by *participating pharmacies*.
- *Benefits* may be subject to *cost-sharing amounts* such as *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 and pharmaceutical utilization management by *Capital*.
- Clinical *medical necessity* determinations are based only on the appropriateness of *prescription drugs* and services and whether *benefits* for such *prescription drugs* and 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* or the *pharmacy benefit manager* (*PBM*). *Members* may contact *Capital* or the *PBM* 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

PRIOR AUTHORIZATION OR OTHER PHARMACEUTICAL UTILIZATION 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 *prior authorization*.

ELECTRONIC MAIL (E-MAIL)

Members can e-mail *Capital* or the *PBM* at *Capital's* website at capbluecross.com. E-mail inquiries are responded to within twenty four (24) hours or one (1) 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 this card and any other identification cards they may have evidencing other coverage **each time they obtain *prescription drugs* and related services**. *ID cards* assist *pharmacists* in submitting *claims* to the proper location for processing and payment.

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 PRESCRIPTION DRUGS AND RELATED SERVICES

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

Members can choose any *retail pharmacy* to obtain *prescription drugs*, although their costs are generally less when they obtain *prescription drugs* from a *participating retail pharmacy*. *Members* have the option to visit a *non-participating retail pharmacy*, but it generally costs them more.

Members who obtain *prescription drugs* through the *mail service pharmacy* must utilize the *mail service pharmacy* designated by *Capital* in order to receive *benefits* under this *coverage*.

Members who use select *specialty prescription drugs* must utilize the *specialty prescription drug* vendor designated by *Capital* in order to receive *benefits* under this *coverage*.

Prescription Drugs and Services Provided by Participating Pharmacies

A *participating pharmacy* is a *pharmacy* or other *prescription drug provider* that is approved by *Capital* and, where licensure is required, is licensed in the Commonwealth of Pennsylvania (or such other jurisdiction approved by *Capital*) and has entered into a *provider* agreement with or is otherwise engaged by *Capital* or its *PBM* to provide *benefits* to *members*. Because *participating pharmacies* 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 using a *participating pharmacy*.

All *participating pharmacies* must seek payment, other than *cost-sharing amounts*, from *Capital* through the *PBM*. ***Participating pharmacies* may not seek payment from *members* for *prescription drugs* and/or services that qualify as *benefits*.** However, a *participating pharmacy* may seek payment from *members* for non-covered *prescription drugs* and services, including specifically excluded *prescription drugs* and services, or services in excess of *benefit lifetime maximums*, *benefit period maximums* or quantity/day supply maximums. The *participating pharmacy* must inform *members* prior to providing the non-covered *prescription drugs* and/or services that they may be liable to pay for these *prescription drugs* and/or services, and the *members* must agree to accept this liability.

The status of a *pharmacy* as a *participating pharmacy* may change from time to time. It is the *member's* responsibility to verify the current status of a *pharmacy*. To find a *participating pharmacy*, *members* can call the telephone number on their *ID card* or 1-800-962-2242 or visit capbluecross.com.

Obtaining Retail Dispensing Benefits

The *identification card* issued by *Capital* shall be presented to the *participating pharmacy* when the *member* applies for *benefits* under the *group contract*. For *covered drugs* dispensed by a *non-participating pharmacy*, or for *covered drugs* purchased without the *identification card*, the *member* must submit a claim for payment to the *PBM* or *Capital*.

For *prescription drugs* obtained from a participating *retail pharmacy*, the *participating pharmacy* will supply *covered drugs* up to a thirty (30) day supply and will not make any charge or collect from the *member* any amount, except for any applicable *cost-sharing amounts*.

Refills may be dispensed under the *group contract* subject to federal and state law limitations, and only in accordance with the number of refills designated on the original *prescription order*. Refills may not be dispensed more than one (1) year after the date of the original *prescription order*. When a *prescription order* is written for a *covered drug* that has previously been dispensed to a *member* or a *prescription order* is presented for a refill, the *covered drug* will be dispensed only at such time as the *member* has used seventy-five (75%) of the previous supply dispensed through *retail dispensing* in accordance with the associated *prescription order*.

Select specialty prescription drugs are available exclusively through *Capital's specialty prescription drug provider*. To obtain the most current list of *specialty prescription drugs*, visit *Capital's* website at capbluecross.com or call the *specialty prescription drug provider* at **1-877-595-3707**.

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

Obtaining Mail Service Dispensing Benefits

To obtain mail order *benefits*, the *member* shall mail the following items to the designated *mail service pharmacy*:

- a completed order form and patient profile;
- applicable *copayment* and/or *coinsurance*; and
- the *prescription order*.

Members can obtain the mail service order forms in the following ways:

- access Capital's website at capbluecross.com;
- contact Customer Service at the phone number listed on their *identification card*; or
- with the delivery of the mail order prescription, subsequent order forms will be supplied.

Maintenance *covered drugs*, subject to any applicable *cost-sharing amount*, may be dispensed such that each *prescription order* shall not exceed a 90-day supply.

Refills may be dispensed under the *group contract*, subject to federal and state law limitations, and only in accordance with the number of refills designated on the original *prescription order*. Refills may not be dispensed more than one (1) year after the date of the original *prescription order*. When a *prescription order* is written for a *covered drug* that has previously been dispensed to a *member* or a *prescription order* is presented for a refill, the *covered drug* will be dispensed only at such time as the *member* has used sixty percent (60%) of the previous supply dispensed through *mail service dispensing* in accordance with the associated *prescription order*.

Certain *prescription drugs* will not be available for *mail service dispensing* due to safety and quality concerns. Such *prescription drugs* will be subject to *retail dispensing* or *specialty pharmacy* dispensing only.

Prescription Drugs and Services Provided by Non-Participating Pharmacies

A *non-participating pharmacy* is a *pharmacy* who does not contract with, directly or indirectly, *Capital* or the *PBM* to provide *benefits* to *members*.

Prescription drugs and/or services provided by *non-participating pharmacies* may require higher *cost-sharing amounts* or may not be covered. If such *prescription drugs* and/or services are covered, *benefits* will be reimbursed based on the *allowable amount* applicable to this *coverage* with *Capital*.

Members may be responsible for the difference between the *non-participating pharmacy's* charge for a *prescription drug* and/or service and the *allowable amount* for that *prescription drug* and/or service. This difference between the *pharmacy's* charge for a *prescription drug* and/or 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 *pharmacy* charged. In addition, all payments are made directly to the *subscriber*. Additional information on balance billing charges can be found in the **Cost-Sharing Descriptions** section of this *Certificate of Coverage*.

The Formulary

Capital's formulary provides *members* access to quality, affordable medications. The *formulary* includes *generic drugs*, *preferred brand drugs* and *non-preferred brand drugs* that have been approved by the U.S. Food and Drug Administration (FDA). The *formulary* is updated by the Capital Pharmacy and Therapeutics Committee on a quarterly basis or when new generic or brand-name medications become available and as discontinued drugs are removed from the marketplace. *Members* can request a current copy of the *formulary* by contacting Customer Service at 1-800-962-2242 or by accessing the Capital BlueCross website at capbluecross.com.

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 in accordance with *Capital's pharmaceutical utilization 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** and **Schedule of Exclusions** sections of this *Certificate of Coverage* for a specific description of the *benefits* and *benefit* limitations provided under this *coverage*.

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

SUMMARY OF COST-SHARING			
	Amounts *Members* Are Responsible For:		
	Retail	***Mail Service***	***Specialty Pharmacy***
Copayments			
• *Generic Drug**	Not Applicable	$25 *copayment*	Not Applicable
• *Preferred Brand Drug*	Not Applicable	$75 *copayment*	Not Applicable
• *Non-Preferred Brand Drug*	Not Applicable	$125 *copayment*	Not Applicable
Deductible	$25 per *member*	Not Applicable	Not Applicable
Coinsurance			
• *Generic Drug**	25% *coinsurance*	Not Applicable	25% coinsurance per 30-day supply (maximum of $150)
• *Preferred Brand Drug*	25% *coinsurance*	Not Applicable	25% coinsurance per 30-day supply (maximum of $150)
• *Non-Preferred Brand Drug*	45% *coinsurance*	Not Applicable	25% coinsurance per 30-day supply (maximum of $150)

*Any *generic drug* cost share does not apply to contraceptives (self-administered). For contraceptive therapeutic categories that have no generic option, an available brand drug as determined by *Capital* may be purchased at no cost share to the *member*.

SUMMARY OF COST-SHARING			
	Amounts *Members* Are Responsible For:		
	Retail	***Mail Service***	***Specialty Pharmacy***
Out-of-Pocket Maximum	$6,600 per *member* $13,200 per family		
This *out-of pocket maximum* amount is combined with, and not in addition to, the *out-of-pocket maximum* amount reflected in the Summary of Cost-Sharing – Medical Benefits. This combined *out-of-pocket maximum* amount can be satisfied with eligible amounts incurred for medical *benefits*, prescription drug *benefits*, or a combination of the two.	The following expenses do not apply to the *out-of-pocket maximum*: • Amounts paid by the *member* to a *non-participating pharmacy* which is in excess of the amount paid to the *member* by *Capital* for *covered drugs*; • Amounts paid by the *member* for a *brand drug* which are in excess of *Capital's allowable amount* (*ancillary charge*) when a *generic drug* is available and the *prescriber* has not indicated "Brand Medically Necessary" (or substantially similar language); and • Charges exceeding the *allowable amount*.		
Benefit Period Maximum	$2,500 for fertility drugs		
Benefit Lifetime Maximum	Not Applicable	Not Applicable	Not Applicable

SUMMARY OF RESTRICTIONS APPLICABLE TO PRESCRIPTION DRUG BENEFITS			
	Retail	***Mail Service***	***Specialty Pharmacy***
Days Supply	Up to 30 days	Up to 90 days	Up to 30 days
Ample Day Supply Limit Percent of the previous supply dispensed that must be used by the *member* before a refill will be dispensed.	75%	60%	75%
Drug Quantity Management	Applicable		
Prior Authorization	Applicable		
Enhanced *Prior Authorization* (Step Therapy)	Applicable		
Specialty Medication Preferred Network	Applicable		
Generic Substitution Policy	**Restrictive Generic Substitution Program** - When the *member* requests a *prescription order* be dispensed with a *brand drug*, which has an approved *generic drug* equivalent, the *member* is responsible for the applicable *brand drug coinsurance* and/or *copayment* in addition to the difference in cost between such *brand drug* and the *generic drug* equivalent. However, if the *prescriber* requires such *brand drug* be dispensed in place of an approved *generic drug* equivalent, the *member* is responsible for only the applicable *brand drug coinsurance* and/or *copayment*.		

SUMMARY OF BENEFITS

This list of *prescription drug* therapeutic classes is intended to be a summary of the most frequently used *prescription drug* therapeutic classes. It is not a complete list of *prescription drugs.**

Prescription Drug Category	**Retail** (Up to a 30-day supply)	**Mail Service** (Up to a 90-day supply)	***Specialty Pharmacy*** (Up to a 30-day supply)
Contraceptives (Self-Administered)	Covered	Covered	Not Covered
Diabetic Supplies	Covered	Covered	Not Covered
Prenatal Vitamins (Prescription)	Covered	Covered	Not Covered
Topical Retinoid (Acne) Products	Covered	Covered	Not Covered
Anti-flu therapy	Covered	Not Covered	Not Covered
Nicotine Cessation Drugs (Prescription)	Covered	Covered	Not Covered
Over-the-Counter Equivalents	Not Covered	Not Covered	Not Covered
Specialty Drugs (Self-Administered)	Covered	Not Covered	Covered
Fertility Drugs (Self-Administered)	Covered	Covered	Covered
Sexual Dysfunction Drugs	Covered	Covered	Not Covered
Weight Loss Drugs (Prescription)	Covered	Covered	Not Covered
Vitamins (Prescription, Non-Prenatal)	Covered	Covered	Not Covered

*Members should refer to *Capital's formulary* for the most updated *prescription drug* information.

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 amounts*:

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

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

- *Ancillary charges*, as described in the **Generic Substitution** section of this *Certificate of Coverage*.
- Balance billing charges, which *members* pay to a *non-participating pharmacy* and which exceed the *allowable amount*.
- Services for which *benefits* are not provided under the *member's coverage*, without regard to the *pharmacy's* participation status.

COPAYMENT

A *copayment* is a fixed dollar amount that a *member* must pay directly to the *pharmacy* for *benefits* at the time services are rendered. *Copayment* amounts may vary, depending on the type of *prescription drug* for which *benefits* are being provided.

For Example: The *allowable amount* for a particular *prescription drug* provided by a *participating pharmacy* is $60. If the *member's coverage* includes a $10 *copayment* for that particular *prescription drug*, the *participating pharmacy* will collect $10 from the *member* at the time the *prescription drug* is dispensed. This *copayment* is part of the *allowable amount* for the *benefit* provided under the *member's coverage*. Since the *participating pharmacy* already received $10 from the *member*, *Capital*, through its *PBM*, will reimburse the *participating pharmacy* a maximum of $50 for the *prescription drug*. The *participating pharmacy* 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 pharmacy* ($60 – $10 = $50).

The *member* in this example would be responsible for paying the *participating pharmacy* $10, and *Capital* would be responsible for paying the *participating pharmacy* $50. So, in the end, the *participating pharmacy* 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*.

> For Example: The *allowable amount* for a particular *prescription drug* provided by a *participating pharmacy* is $60. If the *member's coverage* includes a $500 *deductible* for *participating pharmacy benefits*, the *member* is responsible for this $60. The *participating pharmacy* will collect this amount from the *member* at the time the *prescription drug* is dispensed. *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 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.

> For Example: The *allowable amount* for a particular *prescription drug* provided by a *participating pharmacy* is $60. Assuming any applicable *deductible* has been met, and the *member's coverage* includes a 10% *coinsurance*, 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 will be reimbursed to the *participating pharmacy*. The *participating pharmacy* will then collect the $6 from the *member* at the time the *prescription drug* is dispensed.
>
> 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 x 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 pharmacy* is calculated differently than a claim for a *participating pharmacy*.

For Example: A *non-participating pharmacy's* billed charge is $100 for a particular *prescription drug*. Assuming the applicable *deductible* has been met and the *member's coverage* includes a 10% *coinsurance*, the *member* would pay the $100 charge directly to the *non-participating pharmacy*. The *member* then submits the claim form to the *PBM*.

In this example, assuming the *allowable amount* is $60, the *PBM* will calculate payment for the claim as follows:

1. Multiply the *allowable* amount by the coinsurance percentage to determine the member's coinsurance amount ($60 x 10% = $6).
2. Subtract the coinsurance amount from the *allowable amount* to determine *Capital's* payment to the *subscriber* ($60 – $6 = $54).

So, the *member* in this example would be responsible for paying a total of $46.

So, in the end, the *non-participating pharmacy* has been paid a total of $100, and the *member's* cost share is $46.

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.*

For Example: Expanding on the previous *coinsurance* example for *participating pharmacies*, the *member* owes the *participating pharmacy* $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 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 day limits or dollar limits; and there may be more than one limit on a specific *benefit*.

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.

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

Pharmacies have an amount that they bill for the *prescription drugs* and/or services furnished to *members*. This amount is called the *pharmacy's* billed charge. There may be a difference between the *pharmacy's* billed charge and the *allowable amount*.

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

- For *participating pharmacies*, the *allowable amount* for a *benefit* is set by the *provider's* contract. These contracts also include language whereby the *pharmacy* 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 a *prescription drug* is set by the *pharmacy* to be $100. *Capital's allowable amount* for this *prescription drug* is $60. If the *pharmacy* is a *participating pharmacy* 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 *pharmacy* will be reimbursed for this *prescription drug*; and the *member* will not be billed for the additional $40.

- For *non-participating pharmacies*, the *allowable amount* for a *benefit* determines the maximum amount *Capital* will pay a *member* for *benefits*. Since the *non-participating pharmacy* does not have a contract to provide *prescription drugs* or services to *Capital members*, the *pharmacy* 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 *pharmacy's* charge. Therefore, the *member* is also responsible for paying the difference between the *pharmacy's* charge and the *allowable amount* in addition to any applicable *cost-sharing amount*. All payment for *prescription drugs* and services provided by a *non-participating pharmacy* will be made to the *subscriber*.

For Example: The billed charge for a *prescription drug* is set by the *pharmacy* to be $100. *Capital's allowable amount* for this *prescription drug* is $60. Since the *non-participating pharmacy* does not have a contract to provide *prescription drugs* or services to *Capital members*, the *member* is responsible for paying the full $100 charge. However, the *member* can file a claim for reimbursement. The maximum payment *Capital* will make to the *subscriber* is the *allowable amount* of $60 minus any applicable *cost sharing amounts*. Assuming the *member* has no other *cost-sharing amount* obligations, the remaining $40 is the *member's* expense (in addition to the *member's* applicable *copayment* or *coinsurance*).

BENEFIT DESCRIPTIONS

Subject to the terms, conditions, definitions 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 prior authorized (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 *prescription drug*, a therapeutic class of *prescription drugs*, and/or a service is a covered *benefit*, to determine the amounts *members* are responsible for paying to *pharmacie*s, and to determine whether any *benefit* limitations/maximums apply to this *coverage*.

Certain *prescription drugs* require *prior authorization* or enhanced prior authorization or are limited to specific quantities by *Capital* or its designee.

SCHEDULE OF LIMITATIONS

The *benefits* provided under the *group contract* are subject to the following limitations:

1. A *participating pharmacy* or *non-participating pharmacy* need not dispense a *prescription order* that for any reason, in its professional judgment, should not be filled.

2. A *member* may purchase a *non-preferred brand drug* if it could be used to treat his or her condition. If, however, a *member* purchases a *non-preferred brand drug*, the *member* may be required to pay a higher *copayment*/*coinsurance*, based on the *member's benefit* plan and as indicated in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

3. A *member* may purchase a *brand drug*, even if an approved *generic drug* equivalent could be used to treat his or her condition. If, however, a *member* purchases a *brand drug* and such approved *generic drug* equivalent is available, the *member* is responsible for paying the applicable *brand drug coinsurance* and/or *copayment* in addition to the difference in cost between the *brand drug* and the approved *generic drug* equivalent, (i.e. ancillary charge) unless the *prescriber* requests that the *brand drug* be dispensed.

4. Refills may be dispensed subject to federal and state law limitations and only in accordance with the number of refills designated on the original *prescription order*. Refills may not be dispensed more than one (1) year after the date of the original *prescription order*. When a *prescription order* is written for a *prescription drug* that has previously been dispensed to a *member* or a *prescription order* is presented for a refill, the *prescription drug* will be dispensed only at such time as the *member* has used sixty percent (60%) of the previous supply dispensed through the designated *mail service pharmacy* or seventy-five (75%) of the previous supply dispensed through a *retail pharmacy* or specialty pharmacy in accordance with the associated *prescription order*.

5. Certain *prescription drugs* will not be available for *mail service dispensing* due to safety or quality concerns. Such *prescription drugs* will be subject to *retail dispensing* or *specialty pharmacy* dispensing only.

6. All *prescription drugs* are subject to availability at the *retail pharmacy*, *specialty pharmacy*, or *mail service pharmacy*.

7. Select *specialty prescription drugs* will be subject to dispensing only through a designated *specialty pharmacy*.

8. *Prescription drugs* classified by the federal government as narcotics may be subject to dispensing or dosage limitations based on standards of good pharmaceutical practice or state or federal regulations.

9. *Capital* reserves the right to determine the reasonable supply of any *prescription drug* based on standards of good pharmaceutical practice.

10. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for the *outpatient* use of the *member*, are subject to quantity limits. *Benefits* for these *prescription drugs* shall be available based on the quantity which *Capital* will determine, in its sole discretion, is a reasonable per prescription or per day supply for *retail dispensing*, *specialty pharmacy* dispensing, or *mail service dispensing*.

11. Certain *prescription drugs* require *prior authorization* for coverage prior to the delivery of *covered drugs*.

12. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for the *outpatient* use of the *member,* are subject to enhanced prior authorization (step therapy).

13. *Prescription drugs* utilized to promote fertility are limited to a *benefit period maximum* of $2,500 per *member* per *benefit period*.

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 *prescription drugs* described or otherwise identified below:

1. Which are not *medically necessary* as determined by *Capital* or its designee;
2. Unless otherwise set forth in the *group contract*, drugs that do not legally require a prescription as determined by *Capital*;
3. For *prescription drugs* that have an over-the-counter equivalent;
4. For devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for *diabetic supplies*;
5. For the administration or injection of *prescription drugs*;
6. For *prescription drugs* received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;
7. For allergy serums, desensitization serums, venom;
8. Which are considered by *Capital* or its designee to be *investigational*;
9. 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;
10. 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;
11. Which are 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;
12. 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*;
13. For the cost of *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;
14. 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;
15. For care of conditions that federal, state or local law requires to be treated in a public facility;
16. Which are court ordered services when not *medically necessary* and/or not a covered *benefit*;
17. Which are 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;

18. Which exceed the *allowable amount*;
19. Which are *cost-sharing amounts*, differences between *brand drug* and *generic drug* prices (i.e. *ancillary charges*), and balances paid to *non-participating pharmacies* required of the *member* under this *coverage*;
20. For *prescription drugs* that require *prior authorization* if *prior authorization* is not obtained before dispensing the *prescription drugs*;
21. For *prescription drugs* that require enhanced prior authorization if *prior authorization* is not obtained before dispensing the *prescription drugs*;
22. For quantities that exceed the limits/levels established by *Capital*;
23. For which a *member* would have no legal obligation to pay;
24. Which are incurred prior to the *member's effective date of coverage*;
25. Which are incurred after the date of termination of the *member's coverage* except as provided for in this *Certificate of Coverage*;
26. Which are received by a *member* in a country with which United States law prohibits transactions;
27. For *prescription drugs* utilized primarily to enhance physical or athletic performance or appearance;
28. For clinical cancer trial costs (e.g., drugs under investigation; patient travel expenses; data collection and analysis services), except for costs directly associated with medical care and complications, related to a *Capital* approved trial, which would normally be covered under standard patient therapy *benefits*;
29. For travel expenses incurred in conjunction with *benefits* unless specifically identified as a covered *benefit* elsewhere in this *Certificate of Coverage*;
30. For all *prescription drugs* and over-the-counter drugs dispensed during travel by a *physician* employed by a hotel, cruise line, spa, or similar facility;
31. For durable medical equipment;
32. For blenderized baby food, regular shelf food, or special infant formula;
33. For immunization agents, biological sera, blood, blood products;
34. For requests for reimbursement of *covered drugs* submitted after the allowed timeframe for reimbursement;
35. For all *prescription drugs* and over-the-counter drugs dispensed in a *physician's* office or by a *facility provider*;
36. For *prescription drugs* utilized to promote hair growth;
37. For *prescription drugs* utilized for cosmetic purposes;
38. For injectable medications that cannot be self-administered;
39. For coverage through coordination of *benefits*;
40. Which are received through the designated and/or *non-participating* mail service *pharmacy* for *mail service dispensing* and submitted for reimbursement under *retail dispensing benefits*;

41. Which are received through a *retail pharmacy* for *retail dispensing* and submitted for reimbursement under *mail service dispensing benefits*;

42. For select *specialty drugs* that are received through a retail or mail service *pharmacy* and submitted for reimbursement under *specialty drug* dispensing *benefits*.

43. For *prescription drugs* utilized in connection with non-covered medical services; and

44. For any other *prescription drugs*, service or treatment, except as provided in this *Certificate of Coverage*.

PHARMACEUTICAL UTILIZATION MANAGEMENT PROGRAMS

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

Pharmaceutical Utilization Management Programs include, but are not limited to:

- Drug Utilization Review;
- *Prior Authorization* and Enhanced *Prior Authorization* (Step Therapy); and
- Drug Quantity Management.

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

DRUG UTILIZATION REVIEW(DUR)

Drug utilization review (DUR) evaluates each *prescription drug* dispensed against the *member's* prescription profile, which reflects all *prescription drugs* acquired from participating *retail pharmacies*, participating *specialty pharmacies*, and participating *mail service pharmacies* while covered by *Capital*. Concurrent DUR alerts the *pharmacist* to clinical and plan-specific criteria/edits warranting consideration prior to dispensing. Retrospective DUR alerts the *prescriber* to potential issues that may require further assessment.

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

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

Investigational Treatment Review

This *coverage* with *Capital* does not include *prescription drugs* and/or services that *Capital* or its designee 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 *prescription drug* and/or service which *Capital* considers to be *investigational*, the *member* is solely responsible for payment of this *prescription drug* and/or service; and the non-covered amount will not be applied to the annual *out-of-pocket maximum* or *deductible,* if applicable.

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

PRIOR AUTHORIZATION

To promote appropriate utilization, selected *prescription drugs* require *prior authorization* before the *prescription drug* is dispensed by the *pharmacy* to be eligible as a *covered drug*. These *prescription drugs* are designated in the *formulary*. A copy of the *formulary* can be requested by calling Customer Service at 1-800-962-2242 or accessed via the Capital BlueCross website at capbluecross.com.

Certain *covered drugs*, which are dispensed pursuant to a prescription order for the *outpatient* use of the *member*, are subject to other limits and/or *prior authorization* requirements, as determined by *Capital* in its sole discretion from time to time and as thereafter communicated to the *members*. For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, the *member* can contact Customer Service at 1-800-962-2242 or access the information on the Capital BlueCross website at capbluecross.com.

Members may initiate a *prior authorization* request via the Capital BlueCross website at capbluecross.com or by calling Customer Service at 1-800-962-2242. *Participating providers* may assist *members* in obtaining the required *prior authorizations*. However, the *member* is ultimately responsible for ensuring the required *prior authorization* is obtained.

A *prior authorization* decision is generally issued within two (2) business days of receiving all necessary information for non-urgent requests.

DRUG QUANTITY MANAGEMENT (QUANTITY LEVEL LIMITS)

To facilitate proper utilization and encourage the use of therapeutically indicated drug regimens, some *prescription drugs*, which are dispensed pursuant to a *prescription order* for the *outpatient* use of the *member*, are limited to specific quantities on a per prescription or per day supply basis.

Benefits for such *covered drugs* shall be available based on the quantity which *Capital* will determine, in its sole discretion, is a reasonable supply for up to thirty (30) days through *retail dispensing* and *specialty pharmacy* dispensing or up to ninety (90) days through *mail service dispensing*; or for each *prescription order*.

These *prescription drugs* are designated in the *formulary*. A copy of the *formulary* can be requested by calling Customer Service at 1-800-962-2242 or accessed via the Capital BlueCross website at capbluecross.com.

For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, the *member* can contact Customer Service at 1-800-962-2242 or access the information on the Capital BlueCross website at capbluecross.com.

RESTRICTIVE GENERIC SUBSTITUTION PROGRAM

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

When the *member* requests a *prescription order* be dispensed with a *brand drug*, which has an approved *generic drug* equivalent, the *member* is responsible for the applicable *brand drug coinsurance* and/or *copayment* in addition to the difference in cost between such *brand drug* and the *generic drug* equivalent.

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

ALTERNATIVE TREATMENT PLANS

Notwithstanding anything under this *coverage* to the contrary, the *contract holder*, in its sole discretion, may elect to provide *benefits*, including but not limited to select products which do not legally require a prescription, pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require *prior authorization* from *Capital*. All decisions regarding the treatment to be provided to a *member* remain the responsibility of the treating *physician* and the *member*.
If the *contract holder* elects to provide alternative *benefits* for a *member* in one instance, it does not obligate the *contract holder* to provide the same or similar *benefits* for any *member* in any other instance, nor can it be construed as a waiver of *Capital's* right to administer this *coverage* thereafter in strict accordance with its express terms.

MEMBERSHIP STATUS

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

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.

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, a Medicare Prescription Drug Plan, or a *Medicare* Advantage product offered by or through arrangements with 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*- RELATED COVERAGE IS THE *MEMBER'S* RESPONSIBILITY.

CLAIMS REIMBURSEMENT

CLAIMS AND HOW THEY WORK

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

Participating Pharmacies

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

Non-Participating Pharmacies

If *members* visit a *non-participating pharmacy*, they will be required to pay for the *prescription drug* and/or service at the time the *prescription drug* is dispensed or at the time the service is rendered. *Non-participating pharmacies* do not file claims on behalf of *Capital's members*. Therefore, *members* need to submit their claim to the *PBM* for reimbursement.

ALLOWABLE AMOUNT

The *benefit* payment amount is based on the *allowable amount* on the date the *prescription drug* is dispensed or the date the service is rendered.

FILING A CLAIM

If it is necessary for *members* to submit a claim to the *PBM*, they should be sure to request an itemized bill from the *pharmacy*. The itemized bill should be submitted to the *PBM* with a completed and signed *Prescription Drug* Claim Form.

Members can obtain a copy of the *Prescription Drug* 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 *Prescription Drug* Claim Form is used. A separate claim form must be completed for each *member* who received *prescription drugs* or services.

Members should review the instructions provided on the back of the claim form and include **all** of the following information with their claim:

1. Identification Number – *subscriber's* nine-digit identification number.
2. Group Number/Group Name – number or name 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 *member* who received the *prescription drugs* and/or service.
6. Patient's Date of Birth – *member's* date of birth by month, day, and year.
7. Patient's Gender – indicate male or female.
8. Patient's Telephone Number – telephone number including area code of *member* who received *prescription drugs* and/or services.
9. Patient's Relationship to *Subscriber* – relationship of the *member* to the *subscriber*.
10. Receipts from *Pharmacy* – original receipts from *pharmacy* showing *pharmacy* name and address, patient name, *prescription drugs* or services received, date each *prescription drug* or service was received, the *prescription order* number, the quantity received, the days supply received, and amount charged for each *prescription drug* or service, and medicine NDC number.

Members must also provide additional information, if applicable, including but not limited to, other insurance payment information.

Where to Submit Prescription Drug Claims

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

CVS Caremark
PO Box 52136
Phoenix, Arizona 85072-2136

Members who need help submitting a *prescription drug* claim can contact Customer Service at the telephone number on their *ID card*.

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 Prescription Drug Claims

Paper claims submitted to the *PBM* are processed within ten (10) business days, on average, of receiving the properly completed claim. *Capital* may extend the filing/processing timeframe 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.

COORDINATION OF BENEFITS (COB)

Coordination of *benefits* is not applicable to this *coverage*.

THIRD PARTY LIABILITY/SUBROGATION

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

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

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

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

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

Third Party Liability

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

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

Workers' Compensation Insurance

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

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

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

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the

contract holder and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to subrogation as described in the **Third Party Liability/Subrogation** section 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 *pharmacy*, 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 *prescription drug* or 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.

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.

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, *prior authorization* 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 PHARMACY

The choice of a *pharmacy* 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 *pharmacy*. *Capital* has no responsibility for a *pharmacy'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 *pharmacy* is not a statement as to the ability, cost or quality of the *pharmacy*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular *pharmacy*. If the *member's participating pharmacy* ceases participation, *Capital*, through the *PBM,* will provide access to other *pharmacies* with similar credentials.

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 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 or its designee 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) year 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 *pharmacy* in excess of the *benefit* amount paid by *Capital*. If requested by the *pharmacy*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

PAYMENTS

Capital or its designee is authorized by the *member* to make payments directly to the *PBM* or to the *pharmacies* 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 *pharmacy* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *pharmacy*. *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

The relationship between *Capital* and *pharmacies* is an independent contractor relationship, whether directly or indirectly. *Pharmacies* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a *pharmacy*. *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* or *pharmacy*.

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

5. 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*.

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

7. A summary of the methodologies used by *Capital* to reimburse *pharmacies* for *covered drugs* and/or covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and a *participating pharmacy* or a *contracting Rx entity*.

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.

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 maximum charge or payment level that *Capital* reimburses, without taking into account *rebates*, if any, and any additional administrative fees, true-up payments, penalties and guarantees, if any, into the calculation, for *benefits* provided to a *member* under the *member's coverage*.

- for *participating pharmacies*, the allowable amount is the lesser of either the *participating pharmacy's* actual charge or the amount agreed to between *Capital* and the *PBM*.
- for *non-participating pharmacies*, the allowable amount is the lesser of the *non-participating pharmacy's* actual charge or the *participating pharmacy level*.

Ancillary Charge(s): The difference in cost between a *generic drug* and a *brand drug*, which the *member* is obligated to pay.

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

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 day supply 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 prescription drugs*, services, *diabetic supplies*, and other supplies covered under, and in accordance with, this *coverage*.

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

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

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.

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*. The *member* must pay coinsurance directly to the *pharmacy* at the time services are rendered. 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*.

Contracting Rx Entities: Pharmaceutical manufacturers, *PBMs* and other third parties with which *Capital* may contract for certain prescription products provided to *members*.

Copayment: The fixed dollar amount that a *member* must pay for certain *benefits*. The *member* must pay copayments directly to the *pharmacy* 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*.

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: *copayments*, *deductibles*, *coinsurance*, *ancillary charges*, and *out-of-pocket maximums*.

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

Covered Drugs: Unless specifically excluded, any and all *prescription drugs* dispensed pursuant to a valid *prescription order* and *diabetic supplies*, in each case for the *outpatient* use of the *member*.

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*.

Diabetic Supplies: Medication and supplies used to treat diabetes, including but not limited to: insulin, needles, and syringes. Diabetic supplies does not include batteries, alcohol swabs, preps and gauze.

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*.

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.

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

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

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by *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.

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

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

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.

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.

Mail Service Dispensing: The dispensing of maintenance *prescription drugs* through the designated *mail service pharmacy* in quantities up to a ninety (90) day supply per *prescription order*.

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

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."

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.

Non-Participating Pharmacy: A *pharmacy* who is not under contract with, directly or indirectly, *Capital* or the *PBM*.

Non-Participating Pharmacy Level: The level of payment made by *Capital* when a *member* receives *benefits* from a *non-participating pharmacy*.

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

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*.

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

Participating Pharmacy(ies): A *pharmacy* or other *prescription drug* provider 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* or its *PBM* to provide *benefits* to *members*. The status of a *pharmacy* as a participating *pharmacy* may change from time to time. It is the *member's* responsibility to verify the current status of a *pharmacy*.

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

Pharmaceutical Utilization Management Programs: Includes, but is not limited to, the following programs:

- Drug Utilization Review;
- *Prior Authorization* and Enhanced *Prior Authorization* (Step Therapy); and
- Drug Quantity Management (Quantity Level Limits).

Pharmacy(ies): A pharmacy or other appropriate *prescription drug* provider that is approved by *Capital* and, where licensure is required, is licensed in the state in which it practices or is located and provides covered services and performs services within the scope of such licensure. Pharmacies include *participating pharmacies* and *non-participating pharmacies*.

Pharmacy Benefit Manager (PBM): The pharmacy benefit manager under contract with *Capital* to, among other things, assist in the administration of the *benefits* under the *group contract*.

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

Preferred Brand Drug: A medication that has been reviewed and approved by the Pharmacy & Therapeutics Committee and found to have a therapeutic advantage or overall value over non-preferred brands that treat the same condition, factoring in safety, efficacy and cost.

Prescriber: A person who is licensed and legally entitled to prescribe *prescription drugs*, including but not limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathic Medicine (D.O.), a Certified Registered Nurse Practitioner, or a Certified Physician Assistant (PA-C).

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

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

Prior Authorization: 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 *prescription drugs* and/or services prior to delivery of services.

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.*

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

Rebates: Certain retrospective discounts, refunds or rebates that are received by *Capital* from *contracting Rx entities* and are based on the utilization of certain prescription products by certain *members*.

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

Retail Pharmacy: Any *pharmacy* which is licensed to sell and dispense *prescription drugs* excluding a *mail service pharmacy* and excluding a *pharmacy* that dispenses *prescription drugs* solely via the Internet.

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

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

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

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

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*.

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.

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 m*ember* may appoint a representative to act on his or her behalf as more fully discussed below. The appeal should include the reason(s) the *member* disagrees with the adverse benefit determination. The appeal must be received by *Capital* within one hundred eighty (180) days after the *member* received notice of the adverse benefit determination. The *member*'s appeal must be sent to:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

The *member* may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, *Capital* will provide the *member* with a full and fair internal review. 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.

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

EXPEDITED APPEAL PROCESS FOR CLAIMS INVOLVING URGENT CARE

Special rules apply to *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 m*ember's benefits* are reduced or terminated.

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

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 m*ember's* behalf, or until the *member* designates a different individual to act as his/her authorized representative.

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

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

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

Applicable Group Numbers

00504099 RX Plan 1 and Plan 2 and Plan 3

January, 2015