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
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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℠) and Vision (BlueCross Vision™) 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.
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
- 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.
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

<table>
<thead>
<tr>
<th></th>
<th>Amounts Members Are Responsible For:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Preferred Brand Drug</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Non-Preferred Brand Drug</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$25 per member</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug*</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Preferred Brand Drug</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Non-Preferred Brand Drug</td>
<td>45% coinsurance</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
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<th>Amounts Members Are Responsible For:</th>
<th>Retail</th>
<th>Mail Service</th>
<th>Specialty Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$6,600 per member</td>
<td>$13,200 per family</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>The following expenses do not apply to the out-of-pocket maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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 &quot;Brand Medically Necessary&quot; (or substantially similar language); and</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Charges exceeding the allowable amount.</td>
<td></td>
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<tr>
<td><strong>Benefit Period Maximum</strong></td>
<td>$2,500 for fertility drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Lifetime Maximum</strong></td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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## SUMMARY OF RESTRICTIONS APPLICABLE TO PRESCRIPTION DRUG BENEFITS

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<th>Retail</th>
<th>Mail Service</th>
<th>Specialty Pharmacy</th>
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</thead>
<tbody>
<tr>
<td><strong>Days Supply</strong></td>
<td>Up to 30 days</td>
<td>Up to 90 days</td>
<td>Up to 30 days</td>
</tr>
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<td><strong>Ample Day Supply Limit</strong></td>
<td></td>
<td></td>
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<tr>
<td>Percent of the previous supply dispensed that must be used by the <em>member</em> before a refill will be dispensed.</td>
<td>75%</td>
<td>60%</td>
<td>75%</td>
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<td><strong>Drug Quantity Management</strong></td>
<td>Applicable</td>
<td></td>
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<td><strong>Prior Authorization</strong></td>
<td>Applicable</td>
<td></td>
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<tr>
<td><strong>Enhanced Prior Authorization (Step Therapy)</strong></td>
<td>Applicable</td>
<td></td>
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<tr>
<td><strong>Specialty Medication Preferred Network</strong></td>
<td>Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic Substitution Policy</strong></td>
<td><strong>Restrictive Generic Substitution Program</strong> - When the <em>member</em> requests a prescription order be dispensed with a <em>brand drug</em>, which has an approved <em>generic drug</em> equivalent, the <em>member</em> is responsible for the applicable <em>brand drug</em> coinsurance and/or copayment in addition to the difference in cost between such <em>brand drug</em> and the <em>generic drug</em> equivalent. However, if the <em>prescriber</em> requires such <em>brand drug</em> be dispensed in place of an approved <em>generic drug</em> equivalent, the <em>member</em> is responsible for only the applicable <em>brand drug</em> coinsurance and/or copayment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Category</td>
<td>Retail (Up to a 30-day supply)</td>
<td>Mail Service (Up to a 90-day supply)</td>
<td>Specialty Pharmacy (Up to a 30-day supply)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------</td>
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<td>-------------------------------------------</td>
</tr>
<tr>
<td>Contraceptives (Self-Administered)</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prenatal Vitamins (Prescription)</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Topical Retinoid (Acne) Products</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Anti-flu therapy</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Nicotine Cessation Drugs (Prescription)</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Over-the-Counter Equivalents</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty Drugs (Self-Administered)</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Fertility Drugs (Self-Administered)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Sexual Dysfunction Drugs</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Weight Loss Drugs (Prescription)</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vitamins (Prescription, Non-Prenatal)</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*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.
Cost-Sharing Descriptions

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 ($60 \times 10\% = 6$).
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 pharmacies, 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.
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.
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.
Pharmaceutical Utilization Management Programs

**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.
Membership Status

holder to ensure that they enroll within the required timeframes. Newly eligible subscribers should consult with the contract holder to determine the timeframes applicable to their coverage. Members should refer to the Timelines for Submission of Enrollment Applications section of this Certificate of Coverage for more details.

Dependent - Newborns

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

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

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

Life Status Change

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

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

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

- The date of marriage, existence of a domestic partnership, birth, adoption or placement for adoption, or in the case of a ward, the date specified in the legal custody order; or
- The date of the loss of the other health insurance coverage.

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

**Group Enrollment Period**

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

**EFFECTIVE DATE OF COVERAGE**

**Initial and Newly Eligible Members**

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

**Life Status**

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

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

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

TERMINATION OF GROUP CONTRACT

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

TERMINATION OF COVERAGE FOR MEMBERS

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

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

- **Subscriber - Coverage** ends on the date in which a subscriber is no longer employed by, or a member of, the company or organization sponsoring this coverage. When coverage of a subscriber is terminated, coverage for all of the subscriber’s dependents is also terminated.

- **Dependent Spouse - Coverage** of a dependent spouse ends on the date in which the dependent spouse ceases to be eligible under this coverage.

- **Dependent Domestic Partner - Coverage** of a dependent domestic partner ends on the date in which the dependent domestic partner ceases to be eligible under this coverage.

- **Child - Coverage** of a child ends on the date in which the child is no longer eligible as described in the Enrollment section of this Certificate of Coverage. However, coverage of a child may continue as a dependent disabled child as described in the Membership Status section of this Certificate of Coverage.

- **Dependent Disabled Child - Coverage** of a dependent disabled child ends when the subscriber does not submit to Capital, through the contract holder, the appropriate information as described in the Membership Status section of this Certificate of Coverage. The subscriber must notify Capital of a change in status regarding a dependent disabled child.

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

- Using an **ID card** to obtain goods or services:
  - Not prescribed or ordered for the subscriber or the subscriber’s dependents or
  - To which the subscriber or the subscriber’s dependents are otherwise not legally entitled.

- Allowing any other person to use an **ID card** to obtain services. If a dependent allows any other person to use an ID card to obtain services, coverage of the dependent who allowed the misuse of the ID card is terminated.

- Knowingly misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by Capital, on any enrollment application form.

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

rights to receive benefits cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity benefits.
CONTINUATION OF COVERAGE AFTER TERMINATION

COBRA COVERAGE

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

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

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

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 group contract; 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.
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;
Definitions

• 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.”
**Definitions**

**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.
**Definitions**

**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.
## How To File An Appeal

### TO APPEAL AN ADVERSE BENEFIT DETERMINATION

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

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

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

Capital BlueCross  
PO Box 779518  
Harrisburg, PA 17177-9518

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

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

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

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

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

### EXPEDITED APPEAL PROCESS FOR CLAIMS INVOLVING URGENT CARE

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

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

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

**HOW TO APPEAL A CONCURRENT CARE CLAIM DETERMINATION**

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

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

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

**DESIGNATING AN INDIVIDUAL TO ACT ON YOUR BEHALF**

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

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

Capital communicates with the *member’s* authorized representative only after Capital receives the completed, signed, and dated authorization form. The *member’s* authorization form will remain in effect until the *member* 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