Reading School District
00530769

PPO N1 Plan

GROUP PREFERRED PROVIDER
CERTIFICATE OF COVERAGE

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

Please note:
To better serve you, members with questions about their coverage should call the Dedicated Customer Service phone number provided for your group at 1-855-383-2583. For your convenience, this number is also located on your identification card.
NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities or whose primary language is not English, such as:
- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic format, other formats).
- Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital BlueCross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluvecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).
欲免费用本国语言咨询传译员，请拨电话 800.962.2242 (TTY: 711).
Để nói chuyện với phiên dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).
Fa koschedrefi swetze mite dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).
무료 전화 통역 서비스 800.962.2242 (TTY: 711).
Per parlare con un interprete nella vostra lingua gratis, chiamare 800.962.2242 (TTY: 711).
Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).
দুটি সারির জন্য ফ্রি হলো তেলেফোন করুন 800.962.2242 (TTY: 711)

للتحدث باللغة العربية مقابلทดลอง، يرجى الاتصال بـ 800.962.2242 (الإتصال المجاني: 711)

Pour parlar à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Aby porozmawiać z tłumaczem w języku polskim, proszę zadzwonić na numer darmowy telefonu 800.962.2242 (TTY: 711).
Pou parler à un interprète sans frais, appelez 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).
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INTRODUCTION

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

THE CAPITAL BLUECROSS FAMILY OF COMPANIES

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

- Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross, offers CareConnect (Gatekeeper PPO), BlueJourney PPO (a Medicare Advantage plan), and Senior (Medicare complementary) coverages.

- Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross, offers Preferred Provider Organization (PPO), 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 BlueJourney HMO (a Medicare Advantage plan) coverages.

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

Coverage is administered by Capital BlueCross and its subsidiary, Capital Advantage Assurance Company.
HOW TO USE THIS DOCUMENT

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

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

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

1. **How to Access Benefits**, which serves as a guide to using and making the most of this coverage.

2. **Summary of Cost-Sharing and Benefits**, which contains a summary of benefits and benefit limitations under this coverage.

3. **Schedule of Exclusions**, which contains a list of the services excluded from this coverage.

4. **Claims Reimbursement**, which contains important information on how to file a claim for benefits.

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

- **Schedule of Preventive Care Services**, which outlines the preventive care benefits available under this coverage.

- **Preauthorization Program**, which outlines the services requiring preauthorization.

- **Disease/Condition Management Programs**, which outlines the Disease Management Programs offered to members.

- **How to File an Appeal**, which outlines how to appeal an adverse benefit determination.
IMPORTANT NOTICES

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

- All of the member’s health care expenses may not be covered. Members should read this Certificate of Coverage carefully to determine which health care services are provided as benefits under their coverage.

- To receive certain benefits or to have benefits paid at the highest allowable level, the member’s coverage may require services to be performed by participating providers.

- Benefits may be subject to cost-sharing amounts such as preauthorization penalties for failure to obtain preauthorization when required, copayments, deductibles, coinsurance, out-of-pocket maximums, benefit period maximums and benefit lifetime maximums. Members should refer to the Summary of Cost-Sharing and Benefits section of this Certificate of Coverage to determine which cost-sharing amounts apply to their coverage.

- Benefits are subject to review for medical necessity and may be subject to clinical management by Capital.

- When applicable, if a member fails to follow Capital’s clinical management requirements, Capital may impose a preauthorization penalty or reduce the level of payment for benefits, even if the benefits are medically necessary. Members should refer to the Clinical Management section of this Certificate of Coverage for the specific requirements applicable to their coverage.

- Clinical medical necessity determinations are based only on the appropriateness of services and whether benefits for such services are provided under this coverage. Capital does not reward individuals or practitioners for issuing denials of coverage or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

- Other companies under contract with Capital may provide certain services, including administrative services, relating to this coverage.

- This Certificate of Coverage replaces any other Certificates of Coverage or Certificates of Insurance that may have been issued to the member previously under the member’s coverage with the Capital BlueCross family of companies.

- The Summary of Benefits and Coverage (SBC) required by PPACA will be provided to members by the contract holder. The SBC contains only a partial description of the benefits, limitations and exclusions of this coverage. It is not intended to be a complete list or complete description of available benefits. In the event there are discrepancies between the SBC and Certificate of Coverage, the terms and conditions of this coverage shall be governed solely by the group contract issued to the contract holder.

- The group contract is nonparticipating in any divisible surplus of premium.

- The group contract is available for inspection at the office of the contract holder during regular business hours.

- Capital does not assume any financial risk or obligation with respect to benefits or claims for such benefits.

- The benefit period for this coverage is the calendar year.
HOW TO CONTACT US

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

TELEPHONE

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

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

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

Physical Disabilities

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

PREAUTHORIZATION OR OTHER CLINICAL MANAGEMENT PROGRAMS

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

INTERNET AND ELECTRONIC MAIL (E-MAIL)

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

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

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

MAIL

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

  Capital BlueCross
  PO Box 779519
  Harrisburg, PA 17177-9519

  Fax: 717-541-6915
IN PERSON

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

2500 Elmerton Avenue
Harrisburg, PA  17177

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

RETAIL CENTERS

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

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

The Promenade Shops at Saucon Valley    or    Hampden Marketplace
2845 Center Valley Parkway, Suite 404/409    4500 Marketplace Way
Center Valley, PA  18034                     Enola, PA 17025

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

LANGUAGE ASSISTANCE

Capital offers language assistance for individuals with limited English proficiency. Language assistance includes interpreting services provided directly in the individual’s preferred language and document translation services available upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

To access these services, individuals can simply call Capital’s Customer Service Department at the telephone numbers listed above.
HOW TO ACCESS BENEFITS

MEMBER IDENTIFICATION CARD (ID CARD)

The member’s identification card is the key to accessing the benefits provided under this coverage with Capital. Members should show their card and any other identification cards they may have evidencing other coverage each time they seek medical services. ID cards assist providers in submitting claims to the proper location for processing and payment.

The following is important information about the ID card:

• **Preauthorization**: The term preauthorization alerts providers that this element of a member’s coverage is present. Members should refer to the Preauthorization Program attachment to this Certificate of Coverage for more information.

• **Suitcase Symbol**: This symbol shows providers that the member’s coverage includes BlueCard® and Blue Cross Blue Shield Global Care. With both programs, members have access to BlueCard participating providers nationwide and worldwide.

• **Copayments**: Providers will use this information to determine the copayment they may collect from members at the time a service is rendered.

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

• Preauthorization instructions and toll-free telephone number.

• General instructions for filing claims.

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

OBTAINING BENEFITS FOR HEALTH CARE SERVICES

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

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

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

Services Provided by Participating Providers

A participating provider is a health care facility provider or a professional provider who is properly licensed, where required, and has a contract with Capital to provide benefits under this coverage. Because participating providers agree to accept Capital’s payment for covered benefits - along with any applicable cost-sharing amounts that members are obligated to pay under the terms of this coverage - as payment in full, members can maximize their coverage and minimize their out-of-pocket expenses by visiting a participating provider.
All participating providers must seek payment, other than cost-sharing amounts, directly from Capital. Participating providers may not seek payment from members for services that qualify as benefits. However, a participating provider may seek payment from members for noncovered services, including specifically excluded services (e.g. cosmetic procedures, etc.), or services in excess of benefit lifetime maximums and benefit period maximums. The participating provider must inform members prior to performing the noncovered services that they may be liable to pay for these services, and the members must agree to accept this liability.

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

Services Provided by Nonparticipating Providers

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

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

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

Emergency Services

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

• Placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

• Serious impairment to bodily functions;

• Serious dysfunction of any bodily organ or part; or

• Other serious medical consequences.

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

Transportation and related emergency services provided by a licensed ambulance service are benefits if the condition qualifies as an emergency service.
In a true emergency, the first concern is to obtain necessary medical treatment; so members should seek care from the nearest appropriate facility provider.

**OUT-OF-AREA SERVICES**

**OVERVIEW**

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

When a member receives care outside *Capital’s service area*, members will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) do not contract with the Host Blue. *Capital* explains below how *Capital* pays both kinds of providers.

**Inter-Plan Arrangements Eligibility – Claim Types**

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

**BlueCard® Program**

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

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

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price *Capital* has used for a member’s claim because they will not be applied after a claim has already been paid.
Nonparticipating Healthcare Providers Outside Capital's Service Area

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

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

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

Special Cases: Value-Based Programs

BlueCard Program –

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

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

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

Blue Cross Blue Shield Global Care

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

If a member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, he/she should call the Blue Cross Blue Shield Global Care service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.
How To Access Benefits

- **Inpatient Services**

In most cases, if a *member* contacts the Blue Cross Blue Shield Global Care service center for assistance, *hospitals* will not require the *member* to pay for covered inpatient services, except for the cost-share amounts/deductibles, *coinsurance*, etc. In such cases, the *hospital* will submit the claims to the Blue Cross Blue Shield Global Care service center to begin claims processing. However, if a *member* pays in full at the time of service, he/she must submit a claim to receive reimbursement for covered healthcare services. A *member* must contact *Capital* to obtain precertification for nonemergency inpatient services.

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Care Claim**

When a *member* pays for covered healthcare services outside the BlueCard service area, he/she must submit a claim to obtain reimbursement. For institutional and professional claims, a *member* should complete a Blue Cross Blue Shield Global Care claim form and send the claim form with the *provider’s* itemized bill(s) to Blue Cross Blue Shield Global Care service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from *Capital*, the Blue Cross Blue Shield Global Care service center or online at www.bcbsglobalcore.com. If a *member* needs assistance with a claim submission, he/she should call the Blue Cross Blue Shield Global Care service center at 1.800.810.BLUDE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.
SUMMARY OF COST-SHARING AND BENEFITS

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

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

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

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

The benefit period for this coverage is the calendar year.

<table>
<thead>
<tr>
<th>SUMMARY OF COST-SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amounts Members Are Responsible For:</strong></td>
</tr>
<tr>
<td><strong>Participating Providers</strong></td>
</tr>
<tr>
<td>Preauthorization Penalty</td>
</tr>
<tr>
<td>Copayments – Additional Copayments may apply. See the Summary of Benefits for details</td>
</tr>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
</tr>
<tr>
<td>Inpatient (Per Admission)</td>
</tr>
<tr>
<td>Deductible (per benefit period)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### SUMMARY OF COST-SHARING

<table>
<thead>
<tr>
<th>Amounts Members Are Responsible For:</th>
<th>Participating Providers</th>
<th>NonParticipating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The deductible does not apply to the following benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency services;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency ambulance services;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care Services;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual screening mammograms;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual screening gynecological examinations;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual screening Papanicolaou smears;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pediatric preventive care (participating providers only);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mandated childhood immunizations;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adult preventive care (participating providers only);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Certain nutritional supplements (see Benefit Descriptions section for more details); and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home health care visits related to childbirth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Not Applicable</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$1,500 per member</td>
<td>$6,350 per member</td>
</tr>
<tr>
<td></td>
<td>$3,000 per family</td>
<td>$12,700 per family</td>
</tr>
<tr>
<td>When the out-of-pocket maximum is reached, payment for all other benefits during the remainder of the benefit period are made at 100% of the allowable amount, except for nonparticipating facility providers, which remain at the percentage of the allowable amount indicated in the Payment Levels for Facility Providers chart in this Summary of Benefits and Cost-Sharing section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following expenses do not apply to the out-of-pocket maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preauthorization penalties;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Charges exceeding the allowable amount; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Expenses incurred for payment of a benefit after any applicable benefit period maximum has been exhausted.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### SUMMARY OF PAYMENT LEVELS FOR FACILITY PROVIDERS

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>NonParticipating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (nonemergency)</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility</td>
<td>Covered in Full after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Birthing Facility</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment Supplier</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Covered in Full deductible waived</td>
<td>Covered in Full deductible waived</td>
</tr>
<tr>
<td>Freestanding Diagnostic Facility</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Freestanding Dialysis Facility</td>
<td>Covered in Full after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home Health Care Agency</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Hospital</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Hospital Laboratory</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Infusion Therapy Provider</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Long Term Acute Care Hospital</td>
<td>Covered in Full after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Orthotic Supplier</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Prosthetic Supplier</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Psychiatric Partial Hospitalization Facility</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Rehabilitation Hospital</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Substance Abuse Treatment Facility</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered in Full deductible waived</td>
<td>Covered in Full, deductible waived</td>
</tr>
</tbody>
</table>
### SUMMARY OF BENEFITS

It is important for members to refer to the Payment Levels for Facility Providers chart to determine the level of payment for facility providers. Members will be responsible for paying the coinsurance percentage reflected in that chart in addition to the coinsurance percentage reflected in this Summary of Benefits chart. Nonparticipating providers may balance bill members.***

<table>
<thead>
<tr>
<th>Amounts Members Are Responsible For:</th>
<th>Limits and Maximums (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Providers</td>
<td>NonParticipating Providers</td>
</tr>
</tbody>
</table>

#### ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>Covered in Full after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Long Term Acute Care Hospital</td>
<td>Covered in Full after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### BLOOD AND ADMINISTRATION

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductibles</td>
<td>20% coinsurance, after units deductible</td>
</tr>
</tbody>
</table>

#### ACUTE INPATIENT REHABILITATION

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductibles</td>
<td>50% coinsurance after deductible</td>
</tr>
</tbody>
</table>

#### SKILLED NURSING FACILITY

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductibles</td>
<td>50% coinsurance after deductibles</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient E&amp;M</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Outpatient E&amp;M (Office Visit)</td>
<td>$15 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit for all other professional providers</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Outpatient Consultations</td>
<td>$15 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit for all other professional providers</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>
SUMMARY OF BENEFITS

*** It is important for members to refer to the Payment Levels for Facility Providers chart to determine the level of payment for facility providers. Members will be responsible for paying the coinsurance percentage reflected in that chart in addition to the coinsurance percentage reflected in this Summary of Benefits chart. Nonparticipating providers may balance bill members. ***

<table>
<thead>
<tr>
<th>Amounts Members Are Responsible For</th>
<th>Limits and Maximums (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participating Providers</strong></td>
<td><strong>NonParticipating Providers</strong></td>
</tr>
<tr>
<td>Retail Clinic</td>
<td>$15 copayment per visit</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>TRANSPLANT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Evaluation, Acquisition and Transplantation</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Blue Distinction Centers for Transplant (BDCT) Travel Expenses</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>$10,000 per transplant episode</td>
</tr>
<tr>
<td><strong>SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>Evaluation &amp; Management</td>
<td>$15 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit for all other professional providers</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgical Procedure</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mastectomy and Related Services</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>MATERNITY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits for Prenatal Services, Delivery and Postpartum Services</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>INFERTILITY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>INTERRUPTION OF PREGNANCY</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>
It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. **

<table>
<thead>
<tr>
<th>Amounts Members Are Responsible For:</th>
<th>Limits and Maximums (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEWBORN CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Radiology Tests (Outpatient Facility Only)</td>
<td>Covered in Full after deductible for outpatient facility procedures for high tech imaging tests (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.) Covered in Full after deductible for outpatient facility procedures for radiology tests other than high-tech radiology tests.</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>Covered in Full after deductible when performed at an independent laboratory Covered in Full after deductible, when performed at a Facility/Hospital owned laboratory</td>
</tr>
<tr>
<td>Medical Tests</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>ALLERGY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>OUTPATIENT THERAPY SERVICES (REHABILITATIVE AND HABILITATIVE)</strong></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy (includes Rehabilitative/Habilitative)</td>
<td>$30 copayment per visit</td>
</tr>
</tbody>
</table>
SUMMARY OF BENEFITS

*** It is important for members to refer to the Payment Levels for Facility Providers chart to determine the level of payment for facility providers. Members will be responsible for paying the coinsurance percentage reflected in that chart in addition to the coinsurance percentage reflected in this Summary of Benefits chart. Nonparticipating providers may balance bill members. ***

<table>
<thead>
<tr>
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<th>Amounts Members Are Responsible For:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Participating Providers</td>
<td>NonParticipating Providers</td>
</tr>
<tr>
<td>Occupational Therapy (includes Rehabilitative/Habilitative)</td>
<td>$30 copayment per visit</td>
<td>20% coinsurance after deductible 12 visits per benefit period (Visit limits not applicable to Mental Health Care and Substance Abuse services)</td>
</tr>
<tr>
<td>Speech Therapy (includes Rehabilitative/Habilitative)</td>
<td>$30 copayment per visit</td>
<td>20% coinsurance after deductible 12 visits per benefit period (Visit limits not applicable to Mental Health Care and Substance Abuse services)</td>
</tr>
<tr>
<td>Respiratory/Pulmonary Rehabilitation Therapy</td>
<td>$30 copayment per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy</td>
<td>Covered in Full after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Manipulation Therapy</td>
<td>$20 copayment per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

RADIATION THERAPY

Benefits | Covered in Full after deductible | 20% coinsurance after deductible |

DIALYSIS TREATMENT

Benefits | Covered in Full after deductible | 20% coinsurance after deductible |

OUTPATIENT CHEMOTHERAPY

Benefits | Covered in Full after deductible | 20% coinsurance after deductible |
**SUMMARY OF BENEFITS**

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<tr>
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<td>NonParticipating Providers</td>
</tr>
</tbody>
</table>

**EMERGENCY AND URGENT CARE SERVICES**

**Emergency Services**
Consultations received in the emergency room are subject to the applicable outpatient consultation copayment.

Inpatient hospital stays as a result of an emergency are reimbursed at the level of payment for inpatient benefits. Observation status is not considered inpatient admission. Any emergency room cost-share will apply to observational care unless admitted inpatient.

<table>
<thead>
<tr>
<th>Emergency Ambulance</th>
<th>Covered in Full, deductible waived. $100 copayment per visit, waived if admitted inpatient Note: Cost share is the same regardless of whether the emergency services are provided by a Participating Provider or a NonParticipating Provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonemergency Ambulance</td>
<td>Covered in Full after deductible 20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

**MEDICAL TRANSPORT**

<table>
<thead>
<tr>
<th>Emergency Ambulance</th>
<th>Covered in Full, deductible waived Note: Cost share is the same regardless of whether the emergency services are provided by a Participating Provider or a Nonparticipating Provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonemergency Ambulance</td>
<td>Covered in Full after deductible 20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH CARE SERVICES**

| Inpatient Services | Covered in Full after deductible 20% coinsurance after deductible |
| Partial Hospitalization | Covered in Full after deductible 20% coinsurance after deductible |
**SUMMARY OF BENEFITS**

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<tbody>
<tr>
<td><strong>Participating Providers</strong></td>
<td><strong>NonParticipating Providers</strong></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>$15 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>$30 copayment per visit for all other professional providers</td>
<td></td>
</tr>
</tbody>
</table>

**SUBSTANCE ABUSE SERVICES**

| Detoxification - Inpatient | Covered in Full after deductible | 20% coinsurance after deductible |
| Rehabilitation – Inpatient | Covered in Full after deductible | 20% coinsurance after deductible |
| Rehabilitation - Outpatient | $15 copayment per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician | 20% coinsurance after deductible |
| $30 copayment per visit for all other professional providers |                                     |

**HOME HEALTH CARE SERVICES**

| Benefits | Covered in Full after deductible | 20% coinsurance after deductible |

**INFUSION/IV THERAPY**

| Benefits | Covered in Full after deductible | 20% coinsurance after deductible |

**HOSPICE CARE**

| Benefits (includes Residential Hospice Care) | Covered in Full after deductible | 30% coinsurance after deductible |

**DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES**

| Benefits | Covered in Full after deductible | 20% coinsurance after deductible |
### SUMMARY OF BENEFITS

***It is important for members to refer to the Payment Levels for Facility Providers chart to determine the level of payment for facility providers. Members will be responsible for paying the coinsurance percentage reflected in that chart in addition to the coinsurance percentage reflected in this Summary of Benefits chart. Nonparticipating providers may balance bill members.***

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</thead>
<tbody>
<tr>
<td><strong>PROSTHETIC APPLIANCES</strong></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Appliances (other than wigs)</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td>Wigs</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>ORTHOTIC DEVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>DIABETIC SUPPLIES</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>NUTRITION THERAPY (COUNSELING AND EDUCATION)</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>ENTERAL NUTRITION</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><em>Enteral nutrition products for certain therapeutic treatments are not subject to deductible. See Benefit Descriptions section for details.</em></td>
<td></td>
</tr>
<tr>
<td><strong>IMMUNIZATIONS AND INJECTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td><strong>MAMMOGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Screening Mammogram</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td>Diagnostic Mammogram</td>
<td>Covered in Full after deductible</td>
</tr>
</tbody>
</table>
**Summary of Cost-Sharing and Benefits**

***It is important for members to refer to the Payment Levels for Facility Providers chart to determine the level of payment for facility providers. Members will be responsible for paying the coinsurance percentage reflected in that chart in addition to the coinsurance percentage reflected in this Summary of Benefits chart. Nonparticipating providers may balance bill members.***

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<td><strong>NonParticipating Providers</strong></td>
</tr>
<tr>
<td><strong>GYNECOLOGICAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Screening Gynecological Exam</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td></td>
<td>One (1) per benefit period</td>
</tr>
<tr>
<td>Screening Pap Smear</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td></td>
<td>One (1) per benefit period</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Pediatric Preventive Care (includes physical examinations, childhood immunizations and tests)</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td>Adult Preventive Care (includes physical examinations, immunizations and tests as well as specific women’s preventive services as required by law)</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered in Full, deductible waived</td>
</tr>
<tr>
<td></td>
<td>Limited to coverage for those prescribed contraceptive products or devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).</td>
</tr>
<tr>
<td>Orthodontic Treatment of Congenital Cleft Palates</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td>Diagnostic Hearing Screening</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td>Vision Care for Illness or Accidental Injury</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td>Nonroutine Foot Care</td>
<td>Covered in Full after deductible</td>
</tr>
<tr>
<td>Routine Costs Associated with Approved Clinical Trials</td>
<td>Covered in Full after deductible</td>
</tr>
</tbody>
</table>
COST-SHARING DESCRIPTIONS

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

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

APPLICATION OF COST-SHARING

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

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

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

In addition, members are responsible for payment of any:

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

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

PREAUTHORIZATION PENALTY

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

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

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

**COPAYMENT**

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

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

**Covered Service Location Cost Sharing**

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

**DEDUCTIBLE**

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

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

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

**COINSURANCE**

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

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

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

**OUT-OF-POCKET MAXIMUM**

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

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

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

**Benefit Period Maximum**

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

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

**Benefit Lifetime Maximum**

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

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

**Balance Billing Charges**

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

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

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

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

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

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

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

ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

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

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

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

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

Long-Term Acute Care Hospital

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

BLOOD AND BLOOD ADMINISTRATION

Benefits for blood and blood administration include: whole blood, the administration of blood, blood processing and blood derivatives used to treat specific medical conditions.

ACUTE INPATIENT REHABILITATION

Benefits for acute inpatient rehabilitation provided in a rehabilitation hospital include services provided when a member requires an intensive level of skilled inpatient rehabilitation services on a daily basis and these skilled
rehabilitation services are provided in accordance with a physician’s order. Capital must concur with the physician’s certification that the care and the inpatient setting are both medically necessary.

**SKILLED NURSING FACILITY**

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

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

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

**Evaluation and Management**

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

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

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

**Consultations**

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

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

Consultations that are not benefits include:

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

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

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

**Transplant Services**

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

**Pre-Transplant Evaluation**

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

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

**Acquisition and Transplantation**

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

- When the transplant requires surgical removal of the donated part from a living donor and both the recipient and donor are covered by *Capital*, *benefits* are provided to both, each pursuant to the terms of each person’s respective contract.

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

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

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

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

Transplantation of placental umbilical cord blood stem cells from related or unrelated donors may be considered *medically necessary* in patients with an appropriate indication for allogeneic stem-cell transplant.
Collection and storage of cord blood from a neonate may be considered *medically necessary* when an allogeneic transplant is imminent in an identified recipient with a diagnosis that is consistent with the possible need for allogeneic transplant.

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

**Post-Transplant Services**

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

**Blue Distinction Centers for Transplant (BDCT)**

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

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

**SURGERY**

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

**Evaluation & Management (E&M)**

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

**Surgical Procedure**

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

**Anesthesia Related to Surgery**

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

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

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

Oral and Orthognathic Surgery

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

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

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

Other Surgeries

Benefits for other specialized surgical procedures include:

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

MATERNITY SERVICES

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

Prenatal Services

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

Delivery

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

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

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

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, members may be required to obtain precertification. For information on precertification, contact the plan administrator.

**Postpartum Services**

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

**INFERTILITY SERVICES**

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

However, treatments or procedures leading to or in connection with assisted fertilization such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT), and artificial insemination are not covered.

**INTERRUPTION OF PREGNANCY**

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

**NEWBORN CARE**

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

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

**DIAGNOSTIC SERVICES**

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

Radiology Tests

Benefits for radiology tests include X-rays, MRI’s (Magnetic Resonance Imaging), CT Scans, Ultrasounds, Echography, and other radiological services performed for the purpose of diagnosing a condition due to an illness or injury.

Laboratory Tests

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

In certain situations, an additional cost-sharing amount may be associated with a lab service performed by a provider other than an independent clinical laboratory (ICL). For a list of independent clinical laboratories, as well as how to access them, members should go to capbluecross.com or contact Capital’s Customer Service Department using the telephone number on the back of their ID card.

Medical Tests

Benefits for diagnostic medical tests include EKG’s, EEG’s, and other diagnostic medical procedures performed for the purpose of diagnosing or treating a disease or condition.

Inpatient admissions that are primarily for diagnostic purposes are not covered.

Other Diagnostic Tests and Services

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

ALLERGY SERVICES

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

Testing

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

Immunotherapy

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

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

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

Allergy Serums

Benefits for allergy serums include the immunizing agent (serum) used in immunotherapy injections as long as the immunotherapy itself is covered.
**THERAPY SERVICES (REHABILITATIVE AND HABILITATIVE)**

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

**Physical Therapy**

*Benefits* for physical therapy include evaluation and treatment by physical means or modalities, such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises or activities performed to relieve pain and restore a level of function following disease, illness or injury.

Benefits for physical therapy include rehabilitative and *habilitative* services.

**Occupational Therapy**

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

Benefits for occupational therapy include rehabilitative and *habilitative* services.

**Speech Therapy**

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

Benefits for speech therapy include rehabilitative and *habilitative* services.

**Respiratory /Pulmonary Rehabilitation Therapy**

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

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

Maintenance respiratory and pulmonary therapy is not covered.

**Cardiac Rehabilitation Therapy**

*Benefits* for cardiac rehabilitation therapy include regulated exercise programs that are proven effective in the physiologic rehabilitation of a patient with a cardiac illness.

Maintenance cardiac therapy is not covered.

**Manipulation Therapy**

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

Maintenance manipulation therapy is not covered.

**Radiation Therapy**

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

**Dialysis Treatment**

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

**Chemotherapy**

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

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

**Emergency and Urgent Care Services**

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

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

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

*Outpatient Surgery* resulting from an emergency room visit (including sutures) is reimbursed at the level of payment for *outpatient surgery* benefits.

*Inpatient hospital* stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*. Observation status is not considered *inpatient admission*. Emergency room *cost-sharing amounts* will apply to observational care unless the *member* is admitted *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient consultation copayment*.

*Benefits* for emergency dental accident services include treatment required only to stabilize the *member* immediately following an accidental injury, which includes injuries caused by a mental condition or an act of domestic violence. Treatment of accidental injuries resulting from chewing or biting is not covered.
If Capital, upon reviewing the emergency room records, determines that the services provided do not qualify as emergency services, those nonemergency services may not be covered or may be reduced according to the limitations of this coverage.

Urgent Care Services

Benefits for services performed in an urgent care center include those that, in the judgment of the provider, are nonlife threatening and urgent and can be treated on other than an inpatient hospital basis and are performed at a freestanding urgent care center by a duly licensed associated physician or allied health professional practicing within the scope of his/her licensure and specialty. Urgent care services are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends.

MEDICAL TRANSPORT

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

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

Emergency Ambulance

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

Nonemergency Ambulance

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

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

MENTAL HEALTH CARE SERVICES

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

Inpatient Services

Benefits for inpatient mental health care services include bed, board and general inpatient nursing services when provided for the treatment of mental illness. Services provided by a professional provider to a member who is an inpatient for mental health care are also covered. Benefits include treatment received at a residential treatment facility when preauthorized and medically necessary.
Partial Hospitalization

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

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

Outpatient Services

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

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

SUBSTANCE ABUSE SERVICES

Detoxification - Inpatient

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

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

Rehabilitation

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

Inpatient — Benefits for inpatient substance abuse rehabilitation include: bed, board and general inpatient nursing services. Substance abuse care provided by a professional provider to a member who is an inpatient for substance abuse rehabilitation is also covered. Benefits include treatment received at a residential treatment facility when preauthorized and medically necessary.

For inpatient rehabilitation, sub-acute residential treatment facilities are covered when medical management services are provided.

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

HOME HEALTH CARE SERVICES

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

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

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

• Medical social service consultation.

No home health care benefits are provided for:

• Drugs provided by the home health care agency with the exception of intravenous drugs administered under a treatment plan approved by Capital;

• Food or home delivered meals;

• Homemaker services such as shopping, cleaning and laundry;

• Maintenance therapy; and

• Custodial care.

**Home Health Care Visits Related to Mastectomies**

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

**Home Health Care Visits Related to Maternity**

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

**INFUSION/IV THERAPY**

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

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

**HOSPICE CARE**

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

All eligible hospice services must be billed by the hospice provider.
Benefits for hospice care include the following services provided to a member by a hospice provider responsible for the member's overall care:

- Professional services provided by a registered nurse or licensed practical nurse;
- Medical and surgical supplies and durable medical equipment;
- Prescribed drugs related to the Hospice diagnosis (drugs and biologicals);
- Oxygen and its administration;
- Therapies (physical therapy, occupational therapy, speech therapy);
- Medical social service consultations;
- Dietitian services;
- Home health aide services;
- Family counseling services;
- Respite care;
- Continuous Home Care provided only during a period of crisis in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms; and
- Inpatient services of an acute medical nature arranged through the hospice provider in a hospital or skilled setting to address short-term pain and/or symptom control that cannot be managed in other settings.

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

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

No hospice care benefits are provided for:

- Volunteers;
- Pastoral services;
Benefit Descriptions

• Homemaker services; and
• Food or home delivered meals.

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

**DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES**

Durable medical equipment consists of items that are:

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

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

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

DME may be rented or purchased based upon:

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

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

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

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

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

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

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

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

ORTHOTIC DEVICES

An orthotic device is a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. Benefits for orthotic devices include the purchase, fitting, necessary adjustment, repairs, and replacement of orthotic devices. Examples of orthotic devices are: diabetic shoes; braces for arms, legs, and back; splints; and trusses.

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

DIABETIC SUPPLIES

Drugs and Supplies

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

Equipment, agents, and orthotics include:

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

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

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

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

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

**ENTERAL NUTRITION**

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

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

Regardless of the percentage nutritional intake, *benefits* for enteral nutrition products for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria are covered and are exempt from *deductibles*; however, all other *member cost-sharing* will apply. Similarly, *benefits* for amino acid-based enteral nutrition products are covered for documented food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders, and short-bowel syndrome; however, all standard *member cost-sharing amounts* (including *deductibles*) will apply.

*Benefits* for *medically necessary* enteral feeding equipment for feeding through a tube are included for individuals with functioning gastrointestinal tracts, but for whom oral feeding is impossible or severely limited.

**IMMUNIZATIONS AND INJECTIONS**

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

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

**MAMMOGRAMS**

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

**Screening Mammogram**

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

Benefits for screening mammograms include one (1) screening mammogram per benefit period for females forty (40) years of age and older. This mammogram is exempt from deductibles, benefit period maximums, and benefit lifetime maximums.

**Diagnostic Mammogram**

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

**GYNECOLOGICAL SERVICES**

**Screening Gynecological Exam**

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

**Screening Papanicolaou Smear**

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

Benefits include one (1) routine screening Papanicolaou smear per benefit period for all female members. This Pap smear is exempt from deductibles, benefit period maximums, and benefit lifetime maximums.

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

PREVENTIVE CARE SERVICES

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

Pediatric

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

Adult

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

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

PERVERSIVE DEVELOPMENT DISORDERS (AUTISM SPECTRUM DISORDERS)

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

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

Diagnostic Assessment

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

Treatment

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

• Developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation;

• Includes short and long-term goals which can be measured objectively;
Benefit Descriptions

- Includes any medically necessary pharmaceutical care, psychiatric care, psychological care, rehabilitative care and therapeutic care that is:
  - Prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner; or
  - Provided by an autism service provider; or
  - Provided by a person, entity or group that works under the direction of an autism service provider.

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

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

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

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

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

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

**OTHER SERVICES**

**Contraceptives**

Unless otherwise covered under a prescription drug program, benefits for contraceptives include those contraceptive products or devices mandated by PPACA including but not limited to contraceptive implants such as intrauterine devices (IUD) and services related to the fitting, insertion, implantation and removal of such devices.
Benefit Descriptions

Orthodontic Treatment of Congenital Cleft Palates

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

Diagnostic Hearing Screening

*Benefits* for hearing services include only hearing screenings for diagnostic purposes. *Hearing aids* and exams for the purchase and fitting of *hearing aids* are not covered.

Vision Care for Illness or Accidental Injury

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

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

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

Nonroutine Foot Care

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

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

Routine Costs Associated With Approved Clinical Trials

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29. For cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the bodily part can be expected, except as otherwise required by law. This exclusion does not apply to cosmetic procedures or services related to cosmetic procedures performed to correct a deformity resulting from birth defect or accidental injury. For purposes of this exclusion, prior surgery is not considered an accidental injury;

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

31. For maintenance therapy services, except as required by law;

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

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

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

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

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

37. For services or supplies that are considered by Capital to be investigational, except routine costs associated with Approved Clinical Trials that have been preauthorized by Capital. Routine costs do not include any of the following:
   a. The investigational drug, biological product, device, medical treatment or procedure itself.
   b. The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
   c. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Approved Clinical Trial.
   d. Member travel expenses.

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

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

40. For back-up or secondary durable medical equipment and prosthetic appliances, except ventilators, and for durable medical equipment requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home;

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

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

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

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

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

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

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

48. For prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device;
49. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, air purifiers and filters, physical fitness or exercise equipment, including, but not limited to inversion, tilt, or suspension device or table, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, incontinence supplies, deodorants, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a provider;

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

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

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

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

54. For all other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this Certificate of Coverage;

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

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

57. For services directly related to the care, filling, removal, or replacement of teeth; orthodontic care; treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth; or for dental implants, except where mandated by law and as specifically provided in this Certificate of Coverage;

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

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

60. For eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to, refractive lenses prescribed for use with an intra-ocular lens transplant;

61. For vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams; prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses;

62. For surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy and refractive keratoplasty;

63. For any treatment or procedure leading to or in connection with assisted fertilization such as, but not limited to in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and artificial insemination;
64. For *infertility* services if the present condition of *infertility* is due, in part or in its entirety, to either party having undergone a voluntary sterilization procedure and/or an unsuccessful reversal of a voluntary sterilization procedure;

65. For donor services related to assisted fertilization;

66. For routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except surgery for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints;

67. For supportive devices of the feet, unless otherwise mandated by law and when not an integral part of a leg brace. Supportive devices of the feet include foot supports, heel supports, shoe inserts, and all foot orthotics, whether custom fabricated or sold as is;

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

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

70. For all prescription and over-the-counter drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan approved by *Capital*;

71. For *inpatient* stays to bring about non-surgical weight reduction;

72. For private duty nursing services;

73. For biofeedback;

74. For acupuncture;

75. For autopsies or any other services rendered after a *member’s* demise;

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

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

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

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

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

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

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

84. For any other service or treatment except as provided in this Certificate of Coverage.
A wide range of Clinical Management Programs are available under this coverage with Capital.

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

Clinical Management Programs include:

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

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

**Utilization Management**

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

**Medical Necessity Review**

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

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

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

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

Even if a participating provider recommends that a member receive services from a nonparticipating provider, the member is responsible for payment of all services determined by Capital to be not medically necessary.
NOTE: A provider’s belief that a service is appropriate for the member does not mean the service is covered. Likewise, a provider’s recommendation to a member to receive a given health care service does not mean that such service is medically necessary and/or a covered service.

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

Investigational Treatment Review

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

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

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

Preauthorization

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

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

Participating providers are responsible for obtaining required preauthorizations.

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

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

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

Concurrent Review Program

The Concurrent Review Program includes concurrent review and Discharge Planning.

Concurrent Review - Concurrent review is conducted by experienced Capital registered nurses and board-certified physicians to evaluate and monitor the quality and appropriateness of initial and ongoing medical care
provided in *inpatient* settings (acute care *hospitals*, skilled nursing facilities, inpatient rehabilitation *hospitals*, and long-term acute care *hospitals*). In addition, the program is designed to facilitate identification and referral of *members* to other Clinical Management Programs, such as Case Management and Disease Management; to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning. A concurrent review decision is generally issued within one (1) day of receiving all necessary information.

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

**Medical Claims Review**

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

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

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

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

**Care Management**

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

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

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

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

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

Specialized Case Management Oncology Program

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

Transplant Case Management Program

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

Case Management Awareness Program

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

Discharge Outreach Call Program

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

Transition of Care Program

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

Emergency Room Utilization Program

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

Disease Management

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

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

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

Maternity Management Program

Precious Baby Prints® is a voluntary Maternity Management Program designed to support expectant mothers who experience both complicated and uncomplicated pregnancies. Program participation extends throughout pregnancy, delivery and postpartum care. The program provides educational information, teaching, and personalized support to pregnant members.
The assessment phase of the program includes a questionnaire that helps to identify members who may be at risk for pregnancy-related complications or who may be experiencing complications. Members identified as being potentially at high risk for complications are assigned a Maternity Case Manager (R.N.) for more intensive personalized services.

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

**QUALITY MANAGEMENT PROGRAM**

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

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

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

**HEALTH EDUCATION AND WELLNESS PROGRAMS**

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

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

**24-Hour Nurse Line**

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

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

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

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

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

Nicotine Cessation Program

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

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

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

HOW WE EVALUATE NEW TECHNOLOGY

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

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

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

• The improvement must be attainable outside the investigational setting.

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

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

**ALTERNATIVE TREATMENT PLANS**

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

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

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

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

ELIGIBILITY

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

Nondiscrimination

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, national 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.

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

An individual must be an unmarried child age twenty-six (26) or older to enroll under this coverage as a disabled dependent child. The child must be:

- A birth child, adopted child, or ward of the subscriber or the subscriber’s spouse;
- Mentally or physically incapable of earning a living; and
- Chiefly dependent upon the subscriber or the subscriber’s spouse 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 Medically Necessary Leave of Absence

Eligibility to enroll under this coverage as a child will be extended past the limiting age when the child’s education program at an accredited postsecondary educational institution has been interrupted due to a medically necessary leave of absence.

Capital shall not terminate coverage of a child due to a medically necessary leave of absence before the earlier of the following:

- The date that is one (1) year after the first day of the medically necessary leave of absence; or
- The date on which the coverage would otherwise terminate under the terms of the group contract.

In order to qualify for this extension of eligibility, the child or subscriber must submit to Capital certification by a treating physician that states the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Extension of Eligibility for Students on Military Duty

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

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

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

In order to qualify for this extension of eligibility the child must submit the following forms to Capital:
• The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the dependent has been placed on active duty;

• The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the dependent is no longer on active duty;

• The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the dependent has reenrolled as a full-time student for the first term or semester starting 60 or more days after the dependent’s release from active duty.

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

**ENROLLMENT**

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

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

**Timelines for Submission of Enrollment Applications**

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

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

**Initial Enrollment**

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

**Newly Eligible Members**

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

**Subscriber**

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

Dependent - Newborns

For thirty-one (31) days following birth, a member’s newborn child is covered under this coverage.

Eligible newborns must be enrolled as a dependent under the group contract or enrolled under a separate contract, within thirty-one (31) days of birth to have ongoing coverage. If the newborn child qualifies as a dependent, under the group contract, 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;
- 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, 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;
- First date after loss of other health insurance coverage; or
- First day 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.

- **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.

- **Retirees – Coverage** of a retiree (as determined by the contract holder) ends on the last day of the month in which the retiree ceases to be eligible under this coverage.

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

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

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

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

The actual termination date is the date specified by the contract holder and approved by Capital. Members should check with the contract holder for details regarding specific termination dates. Except as provided for in this Certificate of Coverage, if a member’s benefits under this coverage are terminated under this section, all
rights to receive benefits cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity benefits.
CONTINUATION OF COVERAGE AFTER TERMINATION

COBRA COVERAGE

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

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

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

ELIGIBILITY FOR CONTINUATION OF COVERAGE

A member whose coverage is about to terminate may be eligible for enrollment in individual products on or off the Marketplace.

Examples of situations in which a member may be eligible to enroll in individual coverage include, but are not limited to:

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

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

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

APPLYING FOR INDIVIDUAL COVERAGE IS THE MEMBER’S RESPONSIBILITY.

If a subscriber (employee) should become deceased during a coverage period, coverage will continue for a spouse and dependents for a maximum period of 6 consecutive months, if such provision is contained in the subscriber’s then current Collective Bargaining Agreement.

COVERAGE FOR MEDICARE-ELIGIBLE MEMBERS

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

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

APPLYING FOR MEDICARE SUPPLEMENTAL OR MEDICARE ADVANTAGE COVERAGE IS THE MEMBER’S RESPONSIBILITY.
Coverage for Totally Disabled Members

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

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

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

whichever occurs first.

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

Applying for coverage for totally disabled members is the member’s responsibility.
CLAIMS AND HOW THEY WORK

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

Participating Providers

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

NonParticipating Providers

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

Out-of-Area Providers

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

ALLOWABLE AMOUNT

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

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

FILING A CLAIM

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

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

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

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

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

*Members* must also provide the following information, if applicable:

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

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

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

A Special Note About Medical Records

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

Where to Submit Medical Claims

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

Capital BlueCross
PO Box 211457
Eagan, MN 55121

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

OUT-OF-COUNTRY CLAIMS

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

Inpatient Hospital Claims

Claims for inpatient hospital services arranged through the Blue Cross Blue Shield Global Care service center require members to pay only the usual cost-sharing amounts. The hospital files the claim for the member. Members who receive inpatient hospital care from a nonparticipating hospital or services that were not coordinated through the Blue Cross Blue Shield Global Care service center may have to pay the hospital and submit the claim to the Blue Cross Blue Shield Global Care service center at P.O. Box 72017, Richmond, VA 23255-2017.

Professional Provider Claims

For all outpatient and professional medical care, the member pays the provider and then submits the claim to the Blue Cross Blue Shield Global Care service center at P.O. Box 72017, Richmond, VA 23255-2017. The claim should be submitted showing the currency used to pay for the services.

International Claim Form

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

Time Frames for Submitting Claims

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

Time Frames Applicable to Medical Claims

If the member’s claim involves a medical service or supply that has not yet been received (pre-service claim), Capital will process the claim within fifteen (15) days of receiving the claim. If the member’s claim involves a medical service or supply that was already received (post-service claim), Capital will process the claim within thirty (30) days of receiving the claim. Capital may extend the fifteen (15) day or thirty (30) day time period one (1) time for up to fifteen (15) days for circumstances beyond Capital’s control. Capital will notify the member prior to the expiration of the original time period if an extension is needed. The member and Capital may also agree to an extension if the member or Capital requires additional time to obtain information needed to process the claim.

Special Time Frames Applicable to “Urgent Care” Claims

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

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

Special Time Frames Applicable to “Concurrent Care” Claims

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

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

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

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

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

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

Definitions Unique to Coordination of Benefits

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

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

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

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

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

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

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

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

Secondary Plan: The Plan that typically determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense deemed customary and reasonable by Capital.
Covered Service: A service or supply specified in This Coverage for which benefits will be provided when rendered by a provider to the extent that such item is not covered completely under the Other Plan.

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

2. A Plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of benefits provision is primary.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

   a. Nondependent or Dependent.

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

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


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

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

   - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or

   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or

   - If one of the Plans does not follow the Birthday Rule, then the Plan of the child’s father is the Primary Plan. This is known as the Gender Rule.
(ii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the child’s health care expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the child’s health care expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;

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

- If there is no court decree allocating responsibility for the child’s health care expenses or coverage, the order of benefits for the child is as follows:
  ◊ The Plan covering the Custodial Parent;
  ◊ The Plan covering the spouse of the Custodial Parent;
  ◊ The Plan covering the noncustodial parent; and then
  ◊ The Plan covering the spouse of the noncustodial parent.

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

c. Both spouses are Active Employees.

(i) If eligible employees are married to each other, the spouse whose birthday falls first during the calendar year will be covered as the subscriber and the other spouse will be covered as a dependent.

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

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

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

e. COBRA or State Continuation Coverage.

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

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the “Nondependent or Dependent” rule can determine the order of benefits.
f. **Longer or Shorter Length of Coverage.**

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

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

**Effect on the Benefits of This Coverage**

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

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

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

**Right to Receive and Release Needed Information**

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

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

**Facility of Payment**

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

**Right of Recovery**

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

Active Employees and Spouses Age 65 and Older

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

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

- The group contract will be primary for any person age sixty-five (65) or older who is an Active Employee (defined as a person with “current employment status” under applicable Medicare Secondary Payer Laws) or the spouse of an Active Employee of any age.

- A member may decline coverage under the group contract and elect Medicare as the primary form of coverage. If the member elects Medicare as the primary form of coverage, the group contract, by law, cannot pay benefits secondary to Medicare for Medicare-covered members. However, the member will continue to be covered by the group contract as primary unless: (a) the member, or the contract holder on behalf of the member, notifies Capital, in writing, that the member does not want benefits under the group contract; or (b) the member otherwise ceases to be eligible for coverage under the group contract.

Disability

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

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

End Stage Renal Disease (ESRD)

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

Retirees

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

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

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

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

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

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

Third Party Liability

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

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

Workers’ Compensation Insurance

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

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

• The employee did not use the provider specified by the employer or the workers’ compensation carrier;

• The workers’ compensation timely filing requirement was not met;

• The employee has entered into a settlement with the employer or workers’ compensation carrier to cover future medical expenses; or
For any other reason, as determined by the *contract holder*.

**Motor Vehicle Insurance**

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

**ASSIGNMENT OF BENEFITS**

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

**PAYMENTS MADE IN ERROR**

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

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

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

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

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

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

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

**MEMBER RIGHTS**

*Members* have a right:

- To be treated with respect and recognition of their dignity and right to privacy at all times, to receive considerate and respectful care regardless of religion, race, color, national origin, age, sex, gender identity or sexual orientation, health status, or financial status.

- To receive information about Capital, its services, its contracted practitioners and providers (including information regarding a provider’s qualifications, such as medical school attended, residency completed, or board certification status), and member rights and responsibilities. *Members* can call Customer Service to obtain this information.

- To make recommendations to the list of member rights and responsibilities.

- To have Capital member literature and material for the member’s use, written in a manner which truthfully and accurately provides relevant information that is easily understood.

- To know the name, professional status, and function of those involved in their care.

- To obtain from their physician complete current information concerning their diagnosis, treatment, and prognosis in terms they can reasonably understand, unless it is not medically advisable to provide such information.

- To candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.

- To participate with practitioners in decision making regarding their health care.

- To know what procedure and treatment will be used so that when they give consent to treatment, it is truly informed consent. *Members* should be informed of any side effects or complications that may arise from proposed procedures and treatment in addition to possible alternative procedures. Their physician is responsible for providing them with information they can understand.

- To be advised if any experimentation or research program is proposed in their case and of their right to refuse participation.

- To refuse any drugs, treatment, or other procedure offered to them to the extent permitted by law and to be informed by their physician of the medical consequences of such refusal.

- To all information contained in their medical record unless access is specifically restricted by the attending physician for medical reasons.

- To expect that all records pertaining to their medical care are treated as confidential unless disclosure is necessary for treatment, payment and operations.
Member Rights and Responsibilities

• To be afforded the opportunity to approve or refuse release of identifiable personal information except when such release is allowed or required by law.

• The right to file dissatisfaction about Capital or the care rendered by their provider and to file an appeal from an adverse benefit determination or final internal adverse benefit determination.

MEMBER RESPONSIBILITIES

Members have a responsibility:

• To follow the rules of membership and to read all materials carefully.

• To carry their Capital ID card with them and present it when seeking health care services.

• To provide Capital with relevant information concerning any additional health insurance coverage which they or any of their dependents may have.

• To timely notify Capital and their employer of any changes in their membership, such as change of address, marital status, etc.

• To seek and obtain services from the primary care physician they have chosen as well as direct access to obstetrical/gynecological care and in emergencies or when their chosen physician has referred them to other participating providers and/or Capital has preauthorized them to do so.

• To communicate openly with the physician they choose by developing a physician-patient relationship based on trust and cooperation.

• To follow the plans and instructions for care that they have agreed upon with their practitioner.

• To ask questions to make certain they understand the explanations and instructions they are given.

• To understand their health problems and participate, to the degree possible, in developing mutually agreed-upon treatment goals.

• To understand the potential consequences if they refuse to comply with treatment plans or recommendations.

• To keep scheduled appointments or give adequate notice of delay or cancellation.

• To pay appropriate copayments and coinsurance to providers when services are received.

• To keep Capital informed of any concerns regarding the medical care they receive.

• To provide information, to the extent possible, that Capital needs to administer coverage and that practitioners need to provide care.

• To treat others with respect and recognition of dignity, and to provide considerate and respectful interaction with others regardless of their religion, race, color, national origin, age, sex, gender identity or sexual orientation, health status, or financial status.
GENERAL PROVISIONS

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

DISCOUNTS AND INCENTIVES
Capital may also make available to its members access to health and wellness related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

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

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

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

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

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

Discretionary Changes by Capital
Capital may change coverage for benefits and any cost-sharing amounts, or otherwise change coverage upon the renewal of the group contract.
Capital will provide the contract holder with an official notice of change at least sixty (60) days prior to the effective date of any change in coverage for benefits.

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

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

CONFORMITY WITH STATE STATUTES

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

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

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

CHOICE OF FORUM

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

CHOICE OF LAW

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

CHOICE OF PROVIDER

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

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

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

ENTIRE AGREEMENT

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

EXHAUST ADMINISTRATIVE REMEDIES FIRST

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

FAILURE TO ENFORCE

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

FAILURE TO PERFORM DUE TO ACTS BEYOND CAPITAL’S CONTROL

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

GENDER

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

IDENTIFICATION CARDS

Capital provides identification cards to all subscribers and other members as appropriate. For purposes of identification and specific coverage information, a member’s ID card must be presented when service is requested.
Identification cards are the property of Capital and should be destroyed when a member no longer has coverage. Upon request, identification cards must be returned to Capital within thirty-one (31) days of the member’s termination. Identification cards are for purposes of identification only and do not guarantee eligibility to receive benefits.

**LEGAL ACTION**

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

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

**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.

**PROOF OF LOSS**

Claims for proof of loss must be submitted within ninety (90) days after completion of the covered services to receive benefits from Capital. Capital will not be liable under this group contract unless proper and prompt notice is furnished to Capital that covered services have been rendered to a member. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the Schedule of Cost Sharing in this Certificate of Coverage. The claims must include the data necessary for Capital to determine benefits. An expense will be considered incurred on the date the service or supply was rendered. Claims should be sent to:

Capital BlueCross  
PO Box 211457  
Eagan, MN 55121

Capital reserves the right to verify the validity of each claim with the provider or pharmacy and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to Capital within the time specified will not reduce any benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will Capital be required to accept the proof of loss more than twelve (12) months after benefits are provided, except if the person lacks legal capacity.

**TIME OF PAYMENT OF CLAIMS**

Claim payment for Benefits payable under this agreement will be processed immediately upon receipt of proper proof of loss.
MEMBER’S PAYMENT OBLIGATIONS

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

PAYMENTS

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

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

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

PAYMENT RECOUPMENT

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

POLICIES AND PROCEDURES

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

RELATIONSHIP OF PARTIES

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

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

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

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

WAIVER OF LIABILITY

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any provider, whether a participating provider or nonparticipating provider, in the course of providing benefits for members.
WORKERS’ COMPENSATION

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

PUBLIC HEALTH EMERGENCY.

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

PHYSICAL EXAMINATION AND AUTOPSY

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

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

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

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

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

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

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

6. A description of the process by which a *participating provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Capital* drug formulary for prescription drugs or biologicals when the formulary’s equivalent has been ineffective in the treatment of the *member’s* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member’s* case, if prescription drugs are provided as a *benefit* under the *member’s coverage*.

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

8. A summary of the methodologies used by *Capital* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and a *participating provider*.

9. A description of the procedures used in *Capital’s* Quality Management Program as well as progress towards meeting goals.

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

**Capital BlueCross**  
PO Box 779519  
Harrisburg, PA 17177-9519

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

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

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

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

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

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

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

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

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

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

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

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  1. The National Institutes of Health (NIH)
  2. Centers for Disease Control and Prevention (CDC)
  3. Agency for Healthcare Research and Quality (AHRQ)
  4. Centers for Medicare and Medicaid Services (CMS)
5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).

6. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
   a. The Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institute of Health, and
   b. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug that is exempt from having such an investigational new drug application.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- placing the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy (with respect to a pregnant woman having contractions, an emergency service would include when there is inadequate time to safely transfer the woman to another *hospital* for delivery or when a transfer may pose a threat to the health or safety of the woman or the unborn child);

- serious impairment to bodily functions;

- serious dysfunction of any bodily organ or part; or

- other serious medical consequences.

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

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

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

**Facility Provider:** Facility *providers* include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Hospital**: A facility provider that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Necessity (Medically Necessary): Shall mean:

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

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

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

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

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

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

Mental Illness/Disorder: A health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and/or impaired functioning.
Negotiated Arrangement (a.k.a., Negotiated National Account Arrangement): An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

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

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

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

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

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

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

Partial Hospitalization: The provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as a mental health care or substance abuse treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. To qualify, the partial hospitalization services must be provided for a minimum of four (4) hours, with a maximum of twelve (12) hours per day without incurring a charge for an overnight stay.

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

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

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

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

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

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

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

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

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

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

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

**Provider Incentive:** An additional amount of compensation paid to a healthcare provider by a BlueCross and/or BlueShield Plan, based on the provider’s compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
**Psychiatric Hospital:** A provider licensed and approved by the state in which it provides health care services, or as otherwise approved by Capital, and which is primarily engaged in providing diagnostic and therapeutic services for the mental health care. Such services are provided by or under the supervision of an organized staff of physicians.

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

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

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

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

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

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

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

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

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

- Covered Services under this Certificate of Coverage that would typically be provided absent an Approved Clinical Trial.
Definitions

• Services and supplies required solely for the provision of the Investigational drug, biological product, device, medical treatment or procedure.

• The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.

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

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

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

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

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

• minimal care, custodial care, ambulatory care, or part-time care services; or

• care or treatment of mental illness or substance abuse.

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

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

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

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

Substance Abuse Treatment Facility: A provider licensed and approved by the state in which it provides health care services, or as otherwise approved by Capital and which primarily provides inpatient detoxification and/or rehabilitation treatment for substance abuse. This facility must also meet all applicable standards set by the state in which health care services are received.
**Surgery:** The performance of operative procedures, consistent with medical standards of practice, which physically changes some body structure or organ and includes usual and related pre-operative and post-operative care.

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

- the individual is unable to perform the substantial and material duties of his/her regular occupation and is not in fact engaged in any occupation for wage or profit; or

- if the individual does not usually engage in any occupation for wage or profit, the *member* is substantially unable to engage in the normal activities of an individual of the same age and sex.

**Urgent Care:** Medical care for an unexpected illness or injury that does not require emergency services but which may need prompt medical attention to minimize severity and prevent complications.

**Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

**Ward:** A child for whom the *subscriber*, the *subscriber’s* spouse has been granted legal custody by a court of competent jurisdiction.
This information highlights the preventive care services available under this **coverage** and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. It is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change.

Your specific needs for preventive services may vary according to your personal risk factors. It is not intended to be a complete list or complete description of available services. In-network preventive services are provided at no Member Cost-share. Additional diagnostic studies may be covered if medically necessary for a particular diagnosis or procedure; if applicable, these diagnostic services may be subject to cost-sharing. Members may refer to the benefit contract for specific information on available **benefits or contact Customer Service at the number listed on their ID card.**

### Schedule for Adults: Age 19+

#### GENERAL HEALTH CARE*

For Routine History and Physical Examination, including pertinent patient education. Adult counseling and patient education include:

<table>
<thead>
<tr>
<th>Women</th>
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<tbody>
<tr>
<td>• Breast Cancer chemoprevention</td>
<td>• Folic Acid (childbearing age)</td>
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<tr>
<td>• Contraceptive methods/counseling†</td>
<td>• Hormone Replacement Therapy (HRT) – risk vs. benefits</td>
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<td>At least annually</td>
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<table>
<thead>
<tr>
<th>Men and Women</th>
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</thead>
<tbody>
<tr>
<td>• Aspirin prophylaxis (high risk)</td>
<td>• Physical Activity</td>
</tr>
<tr>
<td>• Calcium/vitamin D intake</td>
<td>• Seat Belt use</td>
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<tr>
<td>• Drug use</td>
<td>• Statin Medication (high risk)</td>
</tr>
<tr>
<td>• Family Planning</td>
<td>• Unintentional Injuries</td>
</tr>
<tr>
<td>• Fall Prevention (age 65 and older)</td>
<td>At least annually</td>
</tr>
</tbody>
</table>

#### SCREENINGS/PROCEDURES*

**Women (Preventive care for pregnant women, see Maternity section.)**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Bone Mineral Density (BMD) test</td>
<td>Testing every 2 years for women age 19-64 at high risk for Osteoporosis. Once every 2 years for women over age 65 and older.</td>
</tr>
<tr>
<td>BRCA screening/genetic counseling/testing</td>
<td>Beginning at age 19 for high risk women, including those not previously diagnosed with BRCA-related cancer but who have a history of breast cancer, ovarian cancer or other cancer; reassess screening every 5-10 years or as determined by your health care provider.</td>
</tr>
<tr>
<td>Chlamydia and Gonorrhea test</td>
<td>Test all sexually active women from age 19-24 years; women at increased risk at age 25 years and older, as recommended by your health care provider. Suggested testing is every 1-3 years.</td>
</tr>
<tr>
<td>Domestic/Interpersonal/Partner Violence screening/counseling</td>
<td>Intervention services available at least annually for women age 19 and older.</td>
</tr>
<tr>
<td>HIV Screening/Counseling</td>
<td>Age 19 and older: Preventive education and risk-assessment for infection at least annually. More frequently for high risk women.</td>
</tr>
<tr>
<td>Mammogram (2D or 3D)</td>
<td>Beginning at age 40, every 1-2 years.</td>
</tr>
<tr>
<td>Pelvic Exam/Pap Smear/HPV DNA</td>
<td>Pelvic Exam/Pap Smear: Age 21-65: every 3 years; HPV DNA: age 30-65, every 5 years.</td>
</tr>
</tbody>
</table>

**Men**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Abdominal Duplex Ultrasound</td>
<td>One-time screening for abdominal aortic aneurysm in men age 65-75 who have ever smoked.</td>
</tr>
<tr>
<td>Prostate Cancer screening</td>
<td>Every 1-4 years for men 19-49 years of age; Annually for men 50 years of age and older.</td>
</tr>
<tr>
<td>Prostate Specific Antigen</td>
<td>Annually for men 50 years of age and older.</td>
</tr>
</tbody>
</table>

**Men and Women**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol misuse screening/counseling</td>
<td>Behavioral counseling interventions for adults age 19 and older who are engaged in risky or hazardous drinking.</td>
</tr>
<tr>
<td>CT Colonography</td>
<td>Beginning at age 50, every 5 years</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Beginning at age 50, every 10 years.</td>
</tr>
<tr>
<td>Depression screening</td>
<td>Age 19 and older: annually or as determined by your health care provider.</td>
</tr>
<tr>
<td>Diabetes (type 2)/Abnormal Blood Glucose Screening</td>
<td>Test all adults age 40-70 who are overweight or obese; if normal, rescreen every 3 years. If abnormal, offer Intensive Behavioral Therapy (IBT) counseling to promote a healthful diet and physical activity.</td>
</tr>
<tr>
<td>Fasting Lipid Profile</td>
<td>Beginning at age 20, every 5 years.</td>
</tr>
<tr>
<td>Fecal Occult Blood test (gFOBT/FIT)</td>
<td>Beginning at age 50, annually.</td>
</tr>
<tr>
<td>FIT-DNA/Cologuard Test</td>
<td>Beginning at age 50, every 3 years.</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td>Beginning at age 50, every 5 years.</td>
</tr>
<tr>
<td>Hepatitis B test</td>
<td>For adults age 19 and older who have not been vaccinated for hepatitis B virus (HBV) infection and other high risk adults; Periodic repeat testing of adults with continued high risk for HBV infection.</td>
</tr>
<tr>
<td>Hepatitis C test</td>
<td>Offer one-time testing of adults born between 1945 and 1965. Periodic repeat testing of adults with continued high risk for HCV infection.</td>
</tr>
</tbody>
</table>
High Blood Pressure (HBP) | Every 3-5 years for adults age 19-39 with BP<130/85 who have no other risk factors. Annually for adults age 40 and older, and annually for all adults at increased risk for HBP.

HIV test | Routine one-time testing of adults age 19-65 at unknown risk for HIV infection. Periodic repeat testing (at least annually) of all high risk adults age 19 and older.

Latent Tuberculosis Infection Test | At least one-time testing of adults age 19 and older at high risk. Periodic repeat testing of adults with continued high risk for TB infection.

Low-dose CT Scan for Lung Cancer | Annual testing until smoke-free for 15 years for high risk adults 55-80 years of age.

Obesity | Age 19 and older: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).

Obesity/Overweight + Cardiovascular Risk Factor combination | Age 19 and older: (BMI of 25 or greater: Intensive Behavioral Therapy (IBT) counseling available to promote a healthy diet and physical activity).

STI counseling | Age 19 and older for high risk adults: Moderate and Intensive Behavioral Therapy (IBT) counseling available.

Sun/UV (ultraviolet) Radiation Skin Exposure; Skin Cancer counseling | Age 19-24 with fair skin: Counseling to minimize exposure to UV radiation.

Syphilis test | Test all high risk adults age 19 and older; suggested testing at 1-3 year intervals.

Tobacco use assessment/counseling and cessation interventions | Age 19 and older: 2 cessation attempts per year (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); FDA-approved tobacco cessation medications; individualize risk in pregnant women.

**IMMUNIZATIONS**

Hemophilus Influenza type b (Hib) | Age 19 and older Based on individual risk or health care provider recommendation: One or three doses

Hepatitis A (HepA) | Age 19 and older Based on individual risk or health care provider recommendation: Two or three doses

Hepatitis B (HepB) | Age 19 and older Based on individual risk or health care provider recommendation: Three doses

Human Papillomavirus (4vHPV/9vHPV - women) | For women age 19-26: Three doses, if not previously immunized.

Human papillomavirus (4vHPV/9vHPV - men) | For men age 19-21: Three doses, if not previously immunized. Age 22+, as determined by your health care provider.

Influenza** | Age 19 and older One dose annually during influenza season.

Measles/Mumps/Rubella (MMR) | Age 19-60: One or two doses, give as necessary based upon risk and past immunization history.

Meningococcal (conjugate) (MenACWY) or (polysaccharide) (MPSV4) | Age 19 and older Based on individual risk or health care provider recommendation: One or more doses

Meningococcal B (MenB) | Age 19 and older Based on individual risk or health care provider recommendation: Two or three doses

Pneumococcal (conjugate) (PCV13) | Age 19-64: One dose (high risk; serial administration with PPSV23 may be indicated). Beginning at 65: One dose (only if PCV13-naïve; serial administration with PPSV23 may be indicated)

Pneumococcal (polysaccharide) (PPSV23) | Age 19-64: One or two doses (high risk; serial administration with PCV13 may be indicated). Beginning at 65: One dose at least 1 year after PCV13 (regardless of previous PCV13/PPSV23 immunization; serial administration with PCV13 may be indicated).

Tetanus/diphtheria/pertussis (Td/Tdap) | Age 19 and older Td every 10 years (substitute one dose of Tdap for Td, regardless of interval of last booster).

Varicella (Chickenpox) | Beginning at age 19; two doses, as necessary based upon past immunization or medical history.

Zoster (Shingles) | Beginning at age 50; one dose, regardless of prior zoster episodes.

Schedule for Maternity

**SCREENINGS/PROCEDURES**

The recommended services listed below are considered preventive care (including prenatal visits) for pregnant women. You may receive the following screenings and procedures at no member cost share:

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

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other “administrative” exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.
**Schedule for Children: Birth through the end of the month Child turns 19**

### GENERAL HEALTH CARE

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

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

### SCREENINGS/PROCEDURES*  

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<th>Newborn</th>
<th>9-12 months</th>
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<td>Alcohol, tobacco and drug use assessment (CRAFFT)</td>
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<td>Autism screening</td>
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<td>Depressionscreening (PHQ-2)</td>
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<td>Developmental screening</td>
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<td>Domestic/Interpersonal/Intimate Partner Violence</td>
<td>Intervention services available at least annually for adolescents of childbearing age 11 years of age and older.</td>
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<td>Fasting Lipid Profile</td>
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<td>Gonorrhea test</td>
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<td>Hearing screening/risk assessment</td>
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<tr>
<td>Hearing test (objective method)</td>
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<td>Hemoglobin and Hematocrit</td>
<td>✓</td>
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<td>Hepatitis B test</td>
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<td>High blood pressure (HBP)</td>
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<td>HIV risk assessment</td>
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<td>HIV test</td>
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<td>Lead screening test/risk assessment</td>
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<tr>
<td>Lipid screening/risk assessment</td>
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<tr>
<td>Newborn blood screen (as mandated by the PA Department of Health)</td>
<td>✓</td>
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</table>

¹ For sexually active females: suggested testing interval is 1-3 years.

**Notes:**
- Newborn evaluations should include a complete newborn examination, including a thorough history and physical examination, and evaluation for specific congenital anomalies.
- Neonatal screening for phenylketonuria, congenital hypothyroidism, and other conditions should be performed as recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.
- Hepatitis B vaccination is recommended at birth for all newborns. For children who have not been vaccinated for hepatitis B virus (HBV) infection/other high risk; Periodic repeat testing of children with continued high risk for HBV infection.
- High blood pressure (HBP) beginning at 3 years: at every well-child visit. Confirm HBP by measuring outside office setting utilizing Ambulatory Blood Pressure Monitoring (ABPM) before treating.
- Routine one-time testing to occur between ages 15-18 years of age.
- Periodic repeat testing (at least annually) of all high risk children.
<table>
<thead>
<tr>
<th>Immunizations**</th>
<th>2 months, 4 months, 6 months, 15–18 months, 4–6 years</th>
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</thead>
<tbody>
<tr>
<td>Diphtheria/Tetanus/Pertussis (DTaP)</td>
<td>2 months, 4 months, 6 months, 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk</td>
</tr>
<tr>
<td>Hemophilus influenza type b (Hib)</td>
<td>12–23 months (2 doses) (catch-up through age 18) and 2–18 years for those at high risk</td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>Birth, 1–2 months, 6–18 months (catch-up through age 18)</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for individuals at high risk or individualization for non high risk</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>6 months–18 years; annually during flu season</td>
</tr>
<tr>
<td>Meningococcal (MenACWY-D/MenACWY-CRM)</td>
<td>11–12 years, 16 years (catch-up through age 18); 2 months–18 years for those at high risk</td>
</tr>
<tr>
<td>Meningococcal B (MenB)</td>
<td>10–18 years for those at high risk; 16–18 years for individuals not at high risk</td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td>2 months, 4 months, 6 months, 12–15 months (catch up through age 5) and 5–18 years for those at high risk</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>2–18 years (1 or 2 doses)</td>
</tr>
<tr>
<td>Polio (IPV)</td>
<td>2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)</td>
</tr>
<tr>
<td>Rotavirus (RV)</td>
<td>2 months, 4 months or 6 months for specific vaccines</td>
</tr>
<tr>
<td>Tetanus/reduced Diphtheria/Pertussis (Tdap)</td>
<td>11–12 years (catch-up through age 18)</td>
</tr>
<tr>
<td>Varicella/Chickenpox (VAR)</td>
<td>12–15 months, 4–6 years (catch-up through age 18)</td>
</tr>
</tbody>
</table>

1. Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
2. Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.
3. Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (> 4 weeks apart), both of which are covered.
4. Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other “administrative” exams are not covered.
5. Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
6. Capital BlueCross providers should refer to the most recent Formulary that is listed on the Capital BlueCross web site at capbluecross.com.
7. Childhood immunization services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other “administrative” exams are not covered.

**Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.**

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); U.S. Food and Drug Administration (FDA), American Academy of Pediatrics (AAP), Women’s Preventive Services Initiative (WPSI)

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Form C00530769PO10118.docx 107 CBC-086 Preventive Care Services (01/01/2018)
SERVICES REQUIRING PREAUTHORIZATION

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

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

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

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

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

PREAUTHORIZATION PENALTY APPLICABILITY

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

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

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

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

The attached list provides categories of services for which preauthorization is required, as well as specific examples of such services. This list is not all inclusive. For a listing of services currently requiring preauthorization, members and providers may consult capbluecross.com.
**PREAUTHORIZATION PROGRAM**  
**Effective Date:** 01/01/2018  
For PPO, COMP, POS, GPPO, HMO Medical Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Comments</th>
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| **Inpatient Admissions**  | • Acute care  
  • Long-term acute care  
  • Non-routine maternity admissions and newborns requiring continued hospitalization after the mother is discharged  
  • Skilled nursing facilities  
  • Rehabilitation hospitals  
  • Behavioral Health (mental health care/ substance abuse)                                                                                                                                                                                                 | Preauthorization requirements do not apply to services provided by a hospital emergency room provider. If an inpatient admission results from an emergency room visit, notification must occur within two (2) business days of the admission. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify Capital of an admission may result in an administrative denial. Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two (2) business days of the date of admission. |
| **Observation Care Admissions** | • Notification is required for all observation stays expected to exceed 48 hours.  
  • All observation care must meet medical necessity criteria from the first hour of admission.                                                                                                                                                                       | Admissions to observation status require notification within two (2) business days. Failure to notify Capital of an admission may result in an administrative denial.                                                   |
| **Diagnostic Services**   | • Genetic disorder testing except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing.  
  • High tech imaging such as but not limited to: Cardiac nuclear medicine studies including nuclear cardiac stress tests, CT (computerized tomography) scans, MRA (magnetic resonance angiography), MRI (magnetic resonance imaging), PET (positron emission tomography) scans, and SPECT (single proton emission computerized tomography) scans. | Diagnostic services do not require preauthorization when emergently performed during an emergency room visit, observation stay, or inpatient admission.                                                                 |
| **Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants** | Purchases, repairs or rentals for DME regardless of price per unit  

(Note: Capital BlueCross may require rental of a device for a designated time prior to purchase)                                                                 | Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.                                                                                           |
<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Comments</th>
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</table>
| Office Surgical Procedures When Performed in a Facility* | • Aspiration and/or injection of a joint  
• Colposcopy  
• Treatment of warts  
• Excision of a cyst of the eyelid (chalazion)  
• Excision of a nail (partial or complete)  
• Excision of external thrombosed hemorrhoids;  
• Injection of a ligament or tendon;  
• Eye injections (intraocular)  
• Oral Surgery  
• Pain management (including trigger point injections, stellate ganglion blocks, peripheral nerve blocks, and intercostal nerve blocks)  
• Proctosigmoidoscopy/flexible Sigmoidoscopy;  
• Removal of partial or complete bony impacted teeth (if a benefit);  
• Repair of lacerations, including suturing (2.5 cm or less);  
• Vasectomy  
• Wound care and dressings (including outpatient burn care) | The items listed are examples of services considered safe to perform in a professional provider’s office. *Medical necessity* review is required when office procedures are performed in a facility setting. *Members* and *providers* may view a listing of services currently requiring *preauthorization* when performed in a facility at [capbluecross.com](http://capbluecross.com). |
| Outpatient Procedures/ Surgery               | • Weight loss surgery (Bariatric)  
• Meniscal transplants, allografts and collagen meniscus implants (knee)  
• Ovarian and Iliac Vein Embolization  
• Photodynamic therapy  
• Radioembolization for primary and metastatic tumors of the liver  
• Radiofrequency ablation of tumors  
• Transcatheter aortic valve replacement  
• Valvuloplasty | The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at [capbluecross.com](http://capbluecross.com). |
| Therapy Services                             | • Hyperbaric oxygen therapy (non-emergency)  
• Manipulation therapy (chiropractic and osteopathic)  
• Occupational therapy  
• Physical therapy  
• Pulmonary rehabilitation programs | *Preauthorization* requirements for manipulation therapy may vary based upon the *provider* of the services. The specific requirements for *preauthorization* of manipulation therapy may be found in the *Preauthorization Policy* at [capbluecross.com](http://capbluecross.com). |
| Transplant Surgeries                         | Evaluation and services related to transplants                                                                                                                                                                                                                                                                                | *Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate. |

* Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.
### Category: Reconstructive or Cosmetic Services and Items
- Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy)
- Breast Procedures
  - Breast Enhancement (Augmentation)
  - Breast Reduction
  - Mastectomy (Breast removal or reduction) for Gynecomastia
  - Breast Lift (Mastopexy)
  - Removal of Breast implants
  - Correction of protruding ears (Otoplasty)
- Repair of nasal/septal defects (Rhinoplasty/Septoplasty)
- Skin related procedures
  - Acne surgery
  - Dermabrasion
  - Hair removal (Electrolysis/Epilation)
  - Face Lift (Rhytidectomy)
  - Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair)
  - Mohs Surgery when performed on two separate dates of service by the same provider
- Treatment of Varicose Veins and Venous Insufficiency

### Medical Injectables
- Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com

### Investigational and Experimental procedures, devices, therapies, and pharmaceuticals
- Investigational or experimental procedures are not usually covered benefits. Members and providers may request preauthorization for experimental or investigational services/items if there are unique member circumstances.

### New to market procedures, devices, therapies, and pharmaceuticals
- Preauthorization is required during the first two (2) years after a procedure, device, therapy or pharmaceutical enters the market. Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.

### Select Outpatient Behavioral Health Services
- Transcranial Magnetic Stimulation (TMS)
- Partial Hospitalization
- Intensive Outpatient Programs
### Other Services
- Bio-engineered skin or biological wound care products
- Category IDE trials (Investigational Device Exemption)
- Clinical trials (including cancer related trials)
- Enhanced external counterpulsation (EECP)
- Home health care
- Home infusion therapy
- Eye injections (Intravitreal angiogenesis inhibitors)
- Laser treatment of skin lesions
- Non-emergency air and ground ambulance transports
- Radiofrequency ablation for pain management
- Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea
- Enteral feeding supplies and services

### Pain Management
- Interventional Pain Management
  - Joint injections
- Members and providers may view a listing of services currently requiring preauthorization at [capbluecross.com](http://capbluecross.com).

### Oncology Services
- Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, gamma knife, EBRT, IORT, IGRT, and hyperthermia treatments.)
- Members and providers may view a listing of services currently requiring preauthorization at [capbluecross.com](http://capbluecross.com).

### Select Cardiac Services
- Members and providers may view a listing of services currently requiring preauthorization at [capbluecross.com](http://capbluecross.com).

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

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

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

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

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

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

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

- Pediatric Asthma
- Pediatric Diabetes

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

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

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

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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. A rescission of coverage also constitutes an adverse benefit determination.

Internal Appeal Process: Whenever a member disagrees with Capital’s adverse benefit determination, the member may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, the 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. Capital will provide the member, free of charge, (1) with any new or additional evidence considered or relied upon, or generated in connection with the claim as well as (2) any new or additional rationale which may be the basis of a final internal adverse appeal determination as soon as possible and prior to issuing a decision on the appeal in order for the member to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, Capital will utilize health care professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination.

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

External Appeal Process: A member may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination 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 appeals of adverse benefit determinations involving “urgent care decisions.”**

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

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

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

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

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

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

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

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

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

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

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

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

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

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Applicable Group Numbers

00530769 PPO N1 Plan and PPO Plan 4 (Carve-out)

January, 2018