Capital

Saucon Valley School District

00500046

PPO
GROUP PREFERRED PROVIDER BENEFITS BOOKLET

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

Please note:

To better serve you, members with questions about their coverage should call the Dedicated Member Services phone number provided for your group at **1-866-802-4711**. For your convenience, this number is also located on your identification card.

NOTICE OF NONDISCRIMINATION

Discrimination is against the law. Capital Blue Cross 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 Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

We provide language assistance services and auxiliary aids free of charge by calling 800.962.2242 (TTY: 711).

Ofrecemos servicios de asistencia lingüística y ayuda auxiliar sin costo llamando al 800.962.2242 (TTY: 711).

请致电 800.962.2242 (TTY: 711)获取我们免费提供的语言协助服务和辅助工具。

我們免費提供語言協助服務與輔助工具，若有需要請致電 800.962.2242 (TTY:711).

Мы бесплатно предоставляем услуги языковой поддержки и вспомогательные средства по телефону 800.962.2242 (TTY: 711).

Unter der Rufnummer 800.962.2242 (TTY: 711) stellen wir Ihnen kostenlose Sprachassistenzdienste und Hilfsmittel zur Verfügung.

Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các thiết bị hỗ trợ miễn phí thông qua số 800.962.2242 (TTY: 711).

نوفر خدمات المساعدة اللغوية والمساعدات الإضافية مجانًا عن طريق الاتصال بالرقم 800.962.2242 (TTY: 711).

800.962.2242 (TTY: 711)번으로 전화하시면 무료로 언어 지원 서비스와 보조 지원 서비스를 제공해 드립니다.

Prestamos serviços linguísticos e de assistência auxiliar gratuitos ligando para o número 800.962.2242 (TTY: 711).

Nous fournissons des services d'assistance linguistique et des aides auxiliaires à titre gratuit au 800.962.2242 (TTY : 711).

Nou bay sèvis asistans pou lang ak èd siplemantè gratis; pou jwenn èd rele nan 800.962.2242 (TTY: 711).

Forniamo gratuitamente servizi di assistenza linguistica e supporti ausiliari chiamando il numero 800.962.2242 (TTY: 711).

અમે 800.962.2242 (TTY: 711) પર કૉલ કરીને નિઃશુલ્ક ભાષા સહાય સેવાઓ અને સહાયક સહાય પ્રદાન કરીએ છીએ.

Zapewniamy bezpłatne usługi językowe i pomocnicze pod numerem telefonu 800.962.2242 (TTY: 711).

আমরা ভাষা সহায়তা পরিষেবা এবং সহায়ক উপকরণ বিনামূল্যে প্রদান করি। এর জন্য 800.962.2242 (TTY: 711) নম্বরে কল করুন।

भाषा सहायता सेवाएं और सहायक उपकरण निःशुल्क प्राप्त करने के लिए 800.962.2242 (TTY: 711) पर कॉल करें।

Capital Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association.

C-572 (05/14/25)

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WELCOME

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

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

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

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

This *Benefits Booklet* also includes a **Schedule of Preventive Care Services**, which provides guidelines for preventive care benefits.

Let's Get Started

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

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

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

IMPORTANT NOTICES

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

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

HOW TO CONTACT US

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

Online

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

Member Services

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

Call	**800.962.2242 or TTY users call 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital Blue Cross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a Capital Blue Cross Connect Health and Wellness Center	Go to **CapitalBlueCrossConnect.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025 **Capital Blue Cross** 1221 Hamilton Street Allentown, PA 18102

DEFINITIONS

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

Allowed Amount: The maximum charge or payment level that we pay for *benefits* under your *coverage*.

- For *in-network providers*, the allowed amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
- For *out-of-network providers*, the allowed amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Benefits Booklet*. For *out-of-network providers* performing either (1) *emergency services* in the emergency department of a *hospital* (or *independent freestanding emergency department*), (2) non-*emergency services* at certain *in-network facilities* (namely, *hospitals*, *hospital* outpatient departments, critical access hospitals, or *ambulatory surgical facilities*), or (3) air ambulance services, the allowed amount is the *recognized amount*.

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

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

Annual Enrollment: The specified time period each year during which you can sign up for or make changes to coverage.

Applied Behavior Analysis (ABA): The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Authorized Representative: One of the following:

- A person, including a *provider*, to whom a *member* has given express written consent to represent the *member* in a complaint, grievance, adverse benefit determination, internal appeal or external review process.
- A person authorized by law to provide substituted consent for a covered person or enrollee; or
- A family member or *provider* involved in providing health care to a *member* if the *member* is incapacitated or unable to provide consent because of a medical emergency or to prevent a serious and imminent threat to the *member's* health or safety.

Autism Service Provider: A person, entity or group licensed or certified by the applicable state authority providing treatment for *autism spectrum disorders* within the scope of their license or certification.

Autism Spectrum Disorders: Any of the disorders defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor.

Behavior Specialist: An individual licensed or certified by the applicable state authority who designs, implements or evaluates a behavior modification intervention component of a treatment plan, including those based on *applied behavior analysis*, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

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

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

Benefits: Those *medically necessary* healthcare services, supplies, equipment and facility charges covered under this *coverage*.

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

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

Birthing Facility: A licensed *facility provider* primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

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

Capital: Capital Blue Cross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

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

Clinical Trial (Approved): A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or other life-threatening disease or condition and meets the following criteria:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  1. The National Institutes of Health (NIH)
  2. Centers for Disease Control and Prevention (CDC)
  3. Agency for Healthcare Research and Quality (AHRQ)
  4. Centers for Medicare and Medicaid Services (CMS)
  5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  6. A qualified nongovernmental research entity named in the guidelines issued by the NIH for center support grants.
  7. The VA, the DOD, or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
     a. The Secretary of Health and Human Services finds to be comparable to the system of peer review of studies and investigations used by the NIH, and
     b. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug that is exempt from having such an *investigational* new drug application.

Coinsurance: The percentage of the *allowed amount* you pay for certain *benefits*. Coinsurance percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

Copayment (Copay): A fixed amount you pay for certain *benefits* at the time of the service. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

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

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

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

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

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

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

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

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

- An ambulance.
- An advanced life support squad vehicle.
- A basic life support squad vehicle.
- A quick response service.
- A special operations EMS service including, but not limited to the following:
  - a tactical EMS service.
  - a wilderness EMS service.
  - an urban search and rescue EMS service.
- A vehicle or service that provides emergency medical services outside of a healthcare facility.

Emergency Services: Any healthcare services provided to a *member* after the onset of a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.
- Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

Emergency services are not subject to *preauthorization* and are available twenty-four (24) hours a day, seven (7) days a week.

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

Facility Providers include:

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

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

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

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

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

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

Group Contract: The agreement between the *contract holder* and us pursuant to which we provide or administer *coverage* under this contract to eligible persons.

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

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for coverage.

Hearing Aid: Any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal or devices that produce sound by vibrating the cochlear fluid through stimulation

of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids.

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

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

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

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

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

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

Identification (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, child, parent, brother, sister, or persons who ordinarily reside in the *subscriber's* or *member's* household.

Independent Freestanding Emergency Department: A health care facility that is geographically separate, distinct, and licensed separately from a *hospital* under applicable state law, and provides any *emergency services*.

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

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

Inpatient: When you are admitted as a patient and spend greater than 23 hours in a *hospital*, *rehabilitation hospital*, *skilled nursing facility,* or *residential treatment facility* and a room and board charge is made. This term may also describe the services you receive while admitted.

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

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

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and final approval has not been granted at the time of its use or proposed use; for up to six (6) months following FDA approval, unless otherwise provided in our applicable medical policies;
- It is the subject of a current investigational new drug or new device application on file with the FDA;
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in medical literature is that further research is needed 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 deciding whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records;
- The protocol(s) by which the treatment or procedure is to be delivered;
- Any consent document you have signed or will be asked to sign, to undergo the treatment or procedure;
- The referred medical or scientific literature on 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; or
- The opinion of a third-party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

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

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

Medical Necessity (Medically Necessary) means:

- 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.
- Follows generally accepted standards of good medical practice.
- Clinically appropriate for the *member's* condition, disease, illness or injury.
- Not primarily for the convenience of the *member* and/or the *member's* family, *physician*, or other healthcare *provider*.

- Not costlier than alternative services or supplies at least as likely to produce equivalent results for the *member's* condition, disease, illness, or injury.

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

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

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

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

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

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

Opioid Treatment Program (OTP): A program that provides opioid use disorder treatment services and may include medication-assisted treatment, counseling, drug testing, and individual and group therapy. Counseling and therapy services are covered in person and/or by using 2-way audio/video communication technology.

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

Out-of-Pocket Maximum: A specified limit to the *cost sharing amount* that you or your dependents may incur for covered services in a *benefit period*. The amount of, and types of cost sharing applied to, the out-of-pocket maximum is described in the **Summary of Cost Sharing and Benefits** section.

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

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

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

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulations, as amended. It is often called the Affordable Care Act (ACA).

Preauthorization: An authorization (or approval) from us or our designee that results from a process used to decide the *medical necessity* of the proposed medical services before delivery of services.

Professional Provider: A person or entity licensed and approved to supply healthcare services, support, or supplies. Includes any of the following:

- Audiologist
- *Autism Service Provider*
- *Behavior Specialist*
- *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
- Social Worker/Other Masters Prepared Therapist
- Speech Language Pathologist

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

Provider Incentive: An added amount of compensation paid to a healthcare *provider* by a Blue Cross and/or Blue Shield Plan, based on the *provider's* compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Hospital: A licensed *facility provider* primarily engaged in providing diagnostic and therapeutic services for behavioral healthcare. Such services are provided by or under the supervision of an organized staff of *physicians*.

Recognized Amount: The amount used to calculate *member cost share amounts* for claims meeting surprise-billing criteria under the No Surprises Act. The recognized amount is the lesser of the *out-of-network provider's* billed charge or our median contracted rate for *in-network providers* for the same or similar item or service received in the same or similar specialty in the same geographic region, calculated in accordance with applicable law.

Reconstructive Surgery: A procedure performed to improve or correct a *functional impairment*, restore a bodily function or correct deformity resulting from *birth defect,* medical condition or disease*,* or accidental injury. The fact that a *member* might suffer psychological consequences from a deformity does not qualify surgery in the absence of bodily *functional impairment*, as being *reconstructive surgery*.

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

Residential Treatment Facility (RTF): A licensed nonhospital *facility provider* that provides *residential treatment*.

Residential Treatment: A 24-hour level of care providing active treatment and close monitoring of behavioral and clinical interventions and activities related to psychiatric treatment, eating disorders, and *substance use disorders*. Residential treatment offers an organized set of services, including diagnostic, medical management and monitoring, and therapeutic services, as well as daily living skill development on a short-term basis. The following are required for residential treatment:

- State licensure as a residential treatment (nonhospital) facility;
- 24-hour registered nurse supervision;
- Primary focus on short-term stabilization, rehabilitation or crisis services;
- *Medical necessity* determination for this level of care;
- The development and implementation of a comprehensive and individualized treatment plan for each *member* through a multidisciplinary team approach which incorporates active treatment; and
- The provision of individual, group and family counseling and other services/interventions following the developed plan.

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

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

- Covered services under this *Benefits Booklet* that typically would be provided absent an a*pproved clinical trial*.
- Services and supplies needed solely to provide 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 needed for the diagnosis or treatment of complications.

Service Area: The 21 Pennsylvania counties in which we offer coverage: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Skilled Nursing Facility: A licensed *provider* primarily engaged in providing daily *skilled nursing services* and related skilled services to *members* requiring 24-hour skilled nursing services but not requiring confinement in an acute care general *hospital*. Such care is provided by or under the

supervision of *physicians*. A skilled nursing facility is not, other than incidentally, a place that provides either of the following:

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

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

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

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

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

Substance Use Disorder Treatment Facility: A licensed *provider* which primarily provides inpatient detoxification and/or rehabilitation treatment for *substance use disorder*. This facility must also meet all applicable standards set by the state in which healthcare services are received.

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

Telehealth: *Medically necessary* services provided to you by an eligible *provider* in which the method of care delivery involves interaction between you and the *provider* using a secure, interactive real-time, audio and/or video telecommunications system or other remote, real-time monitoring technology for the purpose of providing covered services for the evaluation and treatment of conditions that do not require a direct hands-on *provider* examination.

Urgent Care: Medical care for an unexpected illness or injury that does not require *emergency services* but which may need prompt medical attention to minimize severity and prevent complications.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local *providers* that is evaluated against cost and quality metrics/factors and is reflected in *provider* payment.

HOW TO ACCESS BENEFITS

ID Card

Your *ID card* is the key to accessing *benefits* under this *coverage.*

You should show your *ID card* and any *ID cards* you have for other *coverage* each time you need medical services. *Providers* use the *ID card* information to submit claims for payment.

IMPORTANT INFORMATION ABOUT YOUR ID CARD

- ***Preauthorization***: This term alerts *providers* that a service may need to be approved before it is performed to be covered.
- ***Copayments****:* Healthcare *providers* use this information to figure out the *copayment* they may collect from you at the time a service is rendered.

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

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

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

Obtaining Benefits for Healthcare Services

You may choose any *provider* for your care. However, the network status of the *provider* can affect your *coverage* and the amount we pay for a service.

To see if your *provider* is in-network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *ID card*.

NOTE: Some *benefits* may be covered only when you get services from an *in-network provider*.

Services Provided by In-Network Providers

You can minimize your out-of-pocket expenses by visiting an *in-network provider*. *In-network providers* accept our payment for covered *benefits*, along with any applicable *cost sharing amounts* that you must pay, as payment in full. As a result, you can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

Other than *cost sharing amounts*, *in-network providers* may not seek payment from you for services that qualify as *benefits*. However, an *in-network provider* may ask you to pay for noncovered services, excluded services (e.g. cosmetic procedures, etc.), or services over *benefit lifetime maximums* and *benefit period maximums*. Before performing noncovered services, the *in-network provider* must tell you that you may be liable to pay for these services, and you must agree to accept this liability.

The network status of a *provider* may change from time to time. It is your responsibility to check a *provider's* current network status. A list of *in-network providers* is available 24-hours a day on our website at CapitalBlueCross.com. This information includes:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status

Services Provided by Out-of-Network Providers

Out-of-network providers do not have to accept what we pay as payment in full. As a result, receiving services from an *out-of-network provider* may cost you more. You may need to pay the difference, except where prohibited by law, between the amount we allowed for that service (i.e., the *allowed amount*) and the *provider's* charge. This difference is called the balance billing charge, and it can be significant.

In some instances, we, or our contracted vendor, may be able to negotiate a rate with the *provider*. If the *provider* accepts this negotiated rate, we pay the *provider* directly and they will not bill you for the balance of the charge. If the *provider* does not accept a negotiated rate, the claim payment will go directly to you, and you will need to pay the *provider*. In these instances, the *provider* may bill you for the balance of the charge. See the **Cost Sharing Descriptions** section of this *Benefits Booklet* for more information on balance billing charges. Also, certain out-of-network services may not be covered *benefits*. See the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet* for more information.

Note: When you get *emergency services* from an *out-of-network provider*, the in-network level of coverage applies. You will need to pay any applicable *cost sharing amounts* that apply – such as *deductibles*, *coinsurance*, and *copayments*. If you cannot reasonably see an *in-network provider* for *emergency services*, you are not liable for an out-of-pocket expense that is more than it would be if you saw an *in-network provider*. Out-of-network healthcare *providers* performing *emergency services* are prohibited from balance billing *members*.

In addition, for *out-of-network providers* performing: (1) *emergency services* in the emergency department of a hospital (or *independent freestanding emergency department*), (2) non-*emergency services* at certain *in-network facilities* (namely, *hospitals*, *hospital* outpatient departments, critical access hospitals, or *ambulatory surgical facilities*), or (3) air ambulance services, you will be subject to *in-network cost sharing*, calculated based on the *recognized amount*, and the *provider* generally will be prohibited from balance billing you (except where the *out-of-network provider* satisfies advance patient notice and consent requirements).

Emergency Services

An *emergency service* is any healthcare service received after the onset of a medical condition, including a mental health condition or substance use disorder, that shows itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing your health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.

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

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

In a true emergency, you should seek care from the nearest appropriate *facility provider.*

After Normal Business Hours

Contact your *provider* if you need medical services after normal business hours. The *provider's* answering service may take your call. If so, the answering service will contact your *provider* or the *provider* on call, who will contact you as soon as possible. After normal business hours, calls should be limited to medical problems that need immediate attention. However, do not postpone calling your *provider's* office if you believe you need medical attention.

Out-of-Area Services

Inter-Plan Programs

We have a variety of relationships with other Blue Cross or Blue Shield Licensees referred to generally as "Inter-Plan Programs". These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association") and apply when *members* access healthcare services outside of our *service area*.

BlueCard® Program

Members typically receive care outside our *service area* from healthcare *providers* that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area, known as the "Host Blue". Those healthcare *providers* are known as out-of-area/in-network (OOA/IN) *providers. Members* may also obtain care from healthcare *providers* that do not have a contractual agreement with a Host Blue, which are known as out-of-area/out-of-network (OOA/OON) *providers*. Dental care *benefits* (except those paid as medical claims/*benefits*), prescription drug, or vision care benefits are not processed through Inter-Plan Programs.

How we pay *providers* under the *BlueCard® Program* is explained below.

BlueCard®: Out of Area/In-Network Providers

Under the *BlueCard® Program*, when you access covered healthcare services from an OOA/IN *provider*, we will remain responsible for doing what we agreed to in the *group contract*. However, the Host Blue is responsible for handling all interactions with the *provider*.

The amount you pay for covered healthcare services provided by OOA/IN *providers* is calculated based on the lower of:

- The OOA/IN *provider's* billed charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Special Cases: Value-Based Programs

You may access covered services from *providers* that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered through either the *BlueCard® Program* or a Negotiated Arrangement. In either case, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Out-of-Area/Out-of-Network Healthcare Providers

When you receive covered healthcare services from an OOA/OON *provider*, the amount you pay for such services will normally be based on either the Host Blue's out-of-network *provider* local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the OOA/OON *provider* bills and the payment we will make for the covered services as set forth in this paragraph, unless otherwise provided by law. Payments for OOA/OON *emergency services*, certain services provided by OOA/OON *providers* at in-network facilities, and OOA/OON air ambulance services will be governed by applicable federal and state law.

In certain situations, we may pay for covered healthcare services provided by OOA/OON *providers* using other payment methods, such as paying the billed charges, paying the amount we would pay if the services had been obtained within our *service area*, or paying a special negotiated payment. In these situations, you may be responsible for the difference between the amount that the OOA/OON *provider* bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core

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

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

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the *cost sharing amounts* (*deductibles, coinsurance*, etc.). In such cases, the *hospital* will submit the claims to the service center to begin claims processing. However, if you pay in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. ***Members* must contact us to obtain *preauthorization* for nonemergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Continuity of Care

Transitional Period for New Members

New *members* may continue an ongoing course of treatment with an *out-of-network provider* for a transitional period of up to 60 days from the effective date of the *coverage* when approved by us in advance of receiving services. After consultation with you and the healthcare *provider*, we may extend this transitional period if determined to be clinically appropriate. If the new *member* is in the second or third trimester of pregnancy, the transitional period will be extended to postpartum care related to the delivery. All terms and conditions of this *Benefits Booklet*, including *preauthorization* requirements, apply during any transitional period. In addition, the *out-of-network provider* must agree to accept our payment as payment in full.

Transitional Period for Group Contract or In-Network Provider Terminations

If an *in-network provider's* contract is terminated (except when the termination is for cause), you may be able to continue active treatment with the *in-network provider* at in-network *cost sharing amounts*, for a transitional period of up to 90 days. Continuity of care may apply if you are:

- receiving treatment for a serious and complex condition. This can include a sudden illness that requires specialized medical treatment to avoid death or permanent harm (including but not limited to chemotherapy, radiation therapy, or post-operative visits); or a chronic illness or condition that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time;
- in a hospital or other inpatient facility;
- scheduled for nonelective surgery from the *provider*, including postoperative care;
- pregnant and being treated by the *provider* for the pregnancy;
- receiving treatment for a terminal illness (as defined by section 1861(dd)(3)(A) of the Social Security Act) from the *provider*; or
- being treated for a health condition for which a treating *provider* attests that stopping care by that *provider* would worsen the condition or interfere with expected outcomes.

After consultation with you and your *provider*, we may provide the transitional period if it is clinically appropriate. All terms and conditions of this *coverage* and the *group contract*, including *preauthorization*

requirements, will apply during any transitional period. Decisions on continuity of care requests are subject to our internal and external grievance and appeal processes.

If we terminate the contract of an *in-network primary care provider*, we notify every *member* served by that *provider*. Notice is provided in writing 30 days before the effective date of the change or as soon as practicable. You will need to select another *in-network primary care provider*. If asked, we will help you select another *in-network primary care provider*. If you do not select another *in-network primary care provider*, we may assign you to a new one. If the *in-network primary care provider's contract* is terminated for cause, including breach of contract, fraud, criminal activity or posing a danger to a *member* or the health, safety or welfare of the public as determined by us, we are not responsible for coverage of the healthcare services provided to you by the former *in-network provider* after the date of termination, and no *member* has a right to continue with the former *in-network provider.*

SUMMARY OF COST SHARING AND BENEFITS

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

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

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

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE LISTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST. EXCEPT AS REQUIRED BY LAW FOR EMERGENCY SERVICES, AIR AMBULANCE SERVICES, AND OTHER SERVICES RECEIVED IN CERTAIN IN-NETWORK FACILITIES, OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE IN ADDITION TO ANY DEDUCTIBLE, COPAYMENTS OR COINSURANCE YOU ARE REQUIRED TO PAY.

	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DEDUCTIBLE (PER BENEFIT PERIOD)			
Deductible (Per Benefit Period)	$750 per *member*[1] $1,500 combined per *subscriber* and one other member [1] $2,250 per family [1]	$1,500 per *member* $3,000 combined per *subscriber* and one other member $4,500 per family	Copayments and coinsurance do not apply to deductible.
OUT-OF-POCKET MAXIMUM			
Coinsurance Maximum Includes only medical coinsurance amounts; when this amount is satisfied, no further coinsurance is applied to claims for eligible in-network medical services.	Not applicable	Not applicable	

[1] Includes out-of-network emergency services, air ambulance services, and subject to limited provider advance notice and consent requirements, other (non-emergency) provider services received in certain in-network facilities.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS **YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE LISTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST. EXCEPT AS REQUIRED BY LAW FOR EMERGENCY SERVICES, AIR AMBULANCE SERVICES, AND OTHER SERVICES RECEIVED IN CERTAIN IN-NETWORK FACILITIES, OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE IN ADDITION TO ANY DEDUCTIBLE, COPAYMENTS OR COINSURANCE YOU ARE REQUIRED TO PAY.**			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
OUT-OF-POCKET MAXIMUM			
Out-of-Pocket Maximum When you reach your out-of-pocket maximum, we pay all subsequent claims during the remainder of the benefit period at 100% of the allowed amount, except that coinsurance continues to apply for out-of-network facility providers.	$6,600 per member $13,200 combined per *subscriber* and one other member $13,200 per family The In-network out-of-pocket maximum includes all deductible, copayments, and coinsurance for benefits received from in-network providers. [1]	$8,150 per member $16,300 combined per *subscriber* and one other member $16,300 per family Only coinsurance for out-of-network professional providers applies to the out-of-network, out-of-pocket maximum. The following expenses do not apply to the out-of-network out-of-pocket maximum: Deductible • Copayments • Facility provider Coinsurance	The following expenses do not apply to either the in-network or out-of-network out-of-pocket maximum: • Expenses incurred after a benefit period or lifetime maximum has been exhausted do not apply to the out-of-pocket maximum. • Charges exceeding the allowed amount.
ACUTE CARE HOSPITAL ROOM AND BOARD AND ASSOCIATED CHARGES			
Acute Care Hospital	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
Long-Term Acute Care Hospital	No charge after deductible and $200 *inpatient copayment* per admission [2]	Not Covered	
ACUTE INPATIENT REHABILITATION			
Benefits	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	60 days per benefit period Limit not applicable to mental health and substance use disorder services.
ALLERGY SERVICES			
Benefits	No charge after deductible	20% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

YOU WILL BE RESPONSIBLE FOR PAYING THE DEDUCTIBLE, COPAYMENTS AND COINSURANCE PERCENTAGE LISTED IN THIS CHART. UNLESS OTHERWISE STATED, SERVICES THAT APPLY A COPAYMENT DO NOT REQUIRE THAT THE DEDUCTIBLE BE SATISFIED FIRST. EXCEPT AS REQUIRED BY LAW FOR EMERGENCY SERVICES, AIR AMBULANCE SERVICES, AND OTHER SERVICES RECEIVED IN CERTAIN IN-NETWORK FACILITIES, OUT-OF-NETWORK PROVIDERS MAY BALANCE BILL YOU, WHICH WOULD BE IN ADDITION TO ANY DEDUCTIBLE, COPAYMENTS OR COINSURANCE YOU ARE REQUIRED TO PAY.

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
BLOOD AND ADMINISTRATION			
Benefits	No charge after deductible	20% coinsurance after deductible	
DIABETIC SERVICES, SUPPLIES AND EDUCATION			
Benefits	No charge after deductible	20% coinsurance after deductible	
DIAGNOSTIC SERVICES			
Laboratory Tests	No charge after deductible when performed at an independent laboratory or drawn at a physician's office and sent to an independent laboratory. No charge after deductible, when performed at a facility/hospital owned laboratory	20% coinsurance after deductible	
All other Medical Tests	No charge after deductible	20% coinsurance after deductible	
Radiology Tests (Outpatient Facility only)	$75 *copayment* per visit after deductible, for outpatient facility procedures for high tech imaging (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.) No charge after deductible, for outpatient facility procedures for radiology tests other than high-tech radiology tests.	20% coinsurance after deductible	
DIALYSIS TREATMENT			
Benefits	No charge after deductible	20% coinsurance after deductible Not covered for freestanding dialysis treatment facilities	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
Benefits	No charge after deductible	20% coinsurance after deductible	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services	$180 copayment per visit, copayment waived if admitted **Note: Your cost share is the same regardless of whether an in-network provider or an out-of-network provider delivers the emergency services.**		Out-of-network emergency service providers are prohibited from balance billing members, with certain exceptions. **Refer to Emergency and Urgent Care Services benefit description for more details**
Urgent Care Services	$75 *copayment* per visit	20% coinsurance after deductible	
ENTERAL NUTRITION			
Benefits	No charge after deductible	20% coinsurance after deductible	Enteral nutrition products for certain therapeutic treatments are not subject to deductible. See Benefit Descriptions section for details.
FERTILITY SERVICES			
Benefits	No charge after deductible	20% coinsurance after deductible	
GYNECOLOGICAL SERVICES			
Screening Gynecological Exam	No charge deductible waived	20% coinsurance, deductible waived	
Screening Pap Smear	No charge deductible waived	20% coinsurance, deductible waived	
HOME HEALTHCARE SERVICES			
Benefits	No charge after deductible	20% coinsurance after deductible	
HOSPICE CARE			
Benefits (includes Residential Hospice Care)	Inpatient hospice No charge after deductible Outpatient hospice No charge after deductible	30% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
IMMUNIZATIONS AND INJECTIONS (NON-PREVENTIVE)			
Benefits	No charge after deductible	20% coinsurance after deductible	
INFUSION THERAPY			
Benefits	No charge after deductible	20% coinsurance after deductible	
INTERRUPTION OF PREGNANCY			
Benefits	No charge after deductible	20% coinsurance after deductible	
MAMMOGRAMS			
Screening Mammogram	No charge deductible waived	20% coinsurance, deductible waived	
Diagnostic Mammogram	No charge after deductible	20% coinsurance after deductible	
MATERNITY SERVICES (NON-PREVENTIVE)			
Benefits for Prenatal Services, Delivery and Postpartum Services	No charge after deductible	20% coinsurance after deductible	
MEDICAL TRANSPORT			
Emergency Ambulance	No charge deductible waived **Note: Cost share is the same regardless of whether the emergency services are provided by an in-network provider or an out-of-network provider.**		Out-of-network air emergency service providers are prohibited from balance billing members.
Nonemergency Ambulance	No charge after deductible	20% coinsurance after deductible	Out-of-network air emergency service providers are prohibited from balance billing members.
MENTAL HEALTH SERVICES			
Inpatient Services	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
Partial Hospitalization	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
Outpatient Services	$25 *copayment* per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $50 *copayment* per visit for all other *professional providers* [33]	20% coinsurance after deductible	
NEWBORN CARE			
Benefits	No charge after deductible	20% coinsurance after deductible	
NUTRITION THERAPY (COUNSELING AND EDUCATION)			
Benefits	No charge after deductible	Not covered	20 visits for nonpreventive obesity counseling per benefit period 20 visits for chronic management conditions per benefit period Visit limits not applicable to mental health and substance use disorder services.
OFFICE VISITS, CONSULTATIONS, CLINICS AND TELEHEALTH VISITS			
Inpatient Consultations	No charge after deductible	20% coinsurance after deductible	
Outpatient Office Visit, Consultations, Clinics and Telehealth Visits	$25 copayment per visit when provided by any other family practitioner, general practitioner, internist, or pediatrician $50 copayment per visit for all other professional providers	20% coinsurance after deductible	Includes in-person and telehealth visits.
ORTHOTIC DEVICES			
Benefits	No charge after deductible	20% coinsurance after deductible	

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care	No charge deductible waived	20% coinsurance, deductible waived for Pennsylvania mandated childhood immunizations	(Includes physical examinations, childhood immunizations and tests.)
Adult Preventive Care	No charge deductible waived	20% coinsurance after deductible	(Includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law.)
PRIVATE DUTY NURSING SERVICES			
Benefits	No charge after deductible	20% coinsurance after deductible	240 hours per benefit period
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	No charge after deductible	20% coinsurance after deductible	
Wigs	Not covered		
SKILLED NURSING FACILITY			
Benefits	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
SUBSTANCE USE DISORDER SERVICES			
Detoxification – Inpatient	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
Rehabilitation – Inpatient	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
Partial Hospitalization	No charge after deductible and $200 *inpatient copayment* per admission [2]	20% coinsurance after deductible	
Rehabilitation – Outpatient	No charge deductible waived [3]	20% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
SURGERY			
Outpatient Surgery Facility	$30 *copayment* per surgery deductible waived, for *outpatient* surgical procedures performed at an *Ambulatory Surgical Facility*. $30 *copayment* per surgery after deductible, for *outpatient* surgical procedures performed at an Acute Care Hospital facility.	20% coinsurance after deductible at an Acute Care Hospital No charge after deductible at an *Ambulatory Surgical Facility*	
Professional Surgery Services including Anesthesia	No charge after deductible [3]	30% coinsurance after deductible	(Includes Inpatient and Outpatient professional surgical services.)
THERAPY SERVICES			
Cardiac Rehabilitation Therapy	No charge after deductible	20% coinsurance after deductible	
Chemotherapy	No charge after deductible	20% coinsurance after deductible	
Manipulation Therapy	$50 copayment per visit	20% coinsurance after deductible	
Occupational Therapy (includes Rehabilitative/Habilitative)	$50 copayment per visit	20% coinsurance after deductible	10 visits per benefit period Visit limits not applicable to mental health and substance use disorder services
Physical Therapy (includes Rehabilitative/Habilitative)	$50 copayment per visit	20% coinsurance after deductible	
Radiation Therapy	No charge after deductible [3]	20% coinsurance after deductible	
Respiratory/Pulmonary Rehabilitation Therapy	$50 copayment per visit	20% coinsurance after deductible	
Speech Therapy (includes Rehabilitative/Habilitative)	$50 copayment per visit	20% coinsurance after deductible	10 visits per benefit period Visit limits not applicable to mental health and substance use disorder services

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	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
TRANSPLANT SERVICES			
Evaluation, Acquisition and Transplantation	No charge after deductible	20% coinsurance after deductible	
OTHER SERVICES			
Contraceptives	No charge deductible waived	20% coinsurance after deductible	Limited to coverage for those prescribed contraceptive products, services, devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Diagnostic Hearing Services	No charge after deductible	20% coinsurance after deductible	
Foot Care	No charge after deductible	20% coinsurance after deductible	Refer to Foot Care benefit description.
Orthodontic Treatment of Congenital Cleft Palates	No charge after deductible	20% coinsurance after deductible	
Routine Costs Associated with Approved Clinical Trials	No charge after deductible	20% coinsurance after deductible	
Vision Care for Illness or Accidental Injury	No charge after deductible	20% coinsurance after deductible	

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COST SHARING DESCRIPTIONS

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

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

Application of Cost Sharing

We base all *benefit* payments on the *allowed amount*, which is the most that we will pay for *benefits* under this *coverage*. We subtract any applicable *cost sharing amount* from the *allowed amount* before we make payment.

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

- *Deductibles*
- *Copayments*
- *Coinsurance*

In addition, you will need to pay (except where prohibited by law) any:

- Balance billing charges you owe to an *out-of-network provider*.
- Services for noncovered *benefits*, regardless of the *provider's* network status.

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

Cost sharing for facility services: sometimes *members* may receive services in which there are separate charges for the professional and facility services (e.g. laboratory tests, diagnostic tests, outpatient procedures). In such situations, you will need to pay the applicable *cost sharing amount* (*copayment*, *coinsurance*, or *deductible*) for each service until the *member out-of-pocket maximum* has been reached.

Copayment

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

See the **Summary of Cost Sharing and Benefits** section for any *copayments* that apply to your *coverage*.

Deductible

A *deductible* is a dollar amount that an individual *member* or a *subscriber's* entire family must pay before *benefits* are paid under this *coverage*. The *allowed amount* that we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on the *member's coverage*, there may be a *deductible* that applies only to services from *in-network providers* and a separate *deductible* that applies only to services from *out-of-network providers*.

Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. We will apply the amounts satisfied by each *member* toward their individual *deductible* and the family *deductible*. However, the amounts paid by each *member* towards the family *deductible* are limited to the amount of their individual *deductible*. Once the family *deductible* has been met, *benefits* will be paid regardless of whether a family *member* has met his/her individual *deductible*. Generally, satisfaction of *deductible* amounts is determined separately for *in-network* and *out-of-network providers*.

See the **Summary of Cost Sharing and Benefits** section for any *deductibles* that apply to your *coverage*.

Coinsurance

Coinsurance is the percentage of the *allowed amount* you must pay for a *benefit*. Depending on your *coverage*, the *coinsurance* may be calculated as two separate percentages: one for *in-network benefits,* and one for *out-of-network benefits*.

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

See the **Summary of Cost Sharing and Benefits** section for any *coinsurance* that applies to your *coverage*.

Out-of-Pocket Maximum

The *out-of-pocket maximum* is the most that a *member* or a family may be required to pay during a *benefit period*. Depending on the *coverage*, there may be a separate *out-of-pocket maximum* amount for *in-network* services and *out-of-network* services.

The *out-of-pocket maximum* renews each *benefit period*. Once a *member* has met their individual *out-of-pocket maximum*, *benefits* will be paid for that *member* with no additional out-of-pocket expenses for *benefits*. We will apply the amounts satisfied by each *member* toward their individual *out-of-pocket maximum* and the family *out-of-pocket maximum*. However, the amounts paid by each *member* towards the family *out-of-pocket maximum* are limited to the amount of their individual *out-of-pocket maximum*. Once the family *out-of-pocket maximum* has been met, *benefits* will be paid for all family *members* for the rest of the *benefit period* regardless of whether a family *member* has met his/her individual *out-of-pocket maximum*.

See the **Summary of Cost Sharing and Benefits** section for the *out-of-pocket maximum(s)* that apply to your *coverage*.

Benefit Period Maximum

A *benefit period maximum* is the limit of coverage placed on a specific *benefit(s)* in a *benefit period*. These limits may be visit, day, 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*.

See the **Summary of Cost Sharing and Benefits** section for any *benefit period maximums* that apply to your *coverage*.

Benefit Lifetime Maximum

A benefit lifetime maximum is the most we pay for a specific *benefit* for the duration of your *coverage* under the *group contract* or other *contracts* from the Capital Blue Cross family of companies. This *coverage* has no *benefit lifetime maximums* on Essential Health Benefits, as that term is defined by *PPACA*.

See the **Summary of Cost Sharing and Benefits** section for any *benefit lifetime maximums* that apply to your *coverage*.

Balance Billing Charges

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

The interaction between the *allowed amount* and the *provider's* billed charge affects the amount you will have to pay and varies depending on whether the *provider* is *in-network* or *out-of-network*.

- For *in-network providers*, the *provider* has agreed to accept the amount paid by us (minus any *cost sharing amount* you owe) as payment in full. *In-network providers* will not balance bill you for covered services.
- For *out-of-network providers*, because the *out-of-network provider* does not have a contract with us, the *provider* has not agreed to accept *the allowed amount* as payment in full. However, in some instances, our contracted vendor may be able to negotiate a rate with the *provider*. If the *provider* accepts the negotiated rate, we will pay the *provider* directly and they will not bill you for the balance of the charge. If the *provider* does not accept a negotiated rate, the claim payment will go directly to you and you will need to pay the *provider*. In these instances, the *provider* may bill you for the balance of the charge.

  Out-of-network providers performing either (1) *emergency services* in the emergency department of a *hospital* (or *independent freestanding emergency department*), (2) non-*emergency services* at certain in-network facilities (namely, *hospitals*, *hospital* outpatient departments, critical access *hospitals*, or *ambulatory surgical facilities*), or (3) air ambulance services are prohibited from balance billing you, with certain exceptions. In these instances, we will pay the *provider* directly.

  Except as noted above, you may need to pay the difference between the *provider's* billed charge and the *allowed amount* in addition to any applicable *cost sharing amount*. Unless otherwise agreed to by us, or required by law, we will pay you for services performed by an *out-of-network provider.* You are responsible for paying the provider.

Out-of-Network Emergency Providers Notice and Consent Exception

The exception permits *out-of-network emergency providers* performing certain post-stabilization services, and *out-of-network providers* at certain *in-network facilities* (except for those performing *ancillary services*), to balance bill you if they give you written notice that includes the following:

- The *provider's* out-of-network status

- Notice that your consent to receive the items or services from the *out-of-network provider* is optional, and you may instead seek care from an *in-network provider* and be subject to in-network *cost sharing*
- Information about *preauthorization* or care management limitations
- An estimate of charges

The *provider* must also have your written consent to get the services. The notice and your written consent must happen:

- At least 72 hours before you get the services or
- On the date the appointment is scheduled, if less than 72 hours before you get the services (but in no event less than 3 hours before you get the services).

If an *out-of-network provider* satisfies this exception, you will be subject to *cost sharing amounts* at the applicable *out-of-network* level or rate, in addition to being subject to balance billing.

The exception cannot be used in instances where the *out-of-network provider* is the only *provider* at the in-network *facility* who can perform the service (i.e., you cannot choose someone in-network) or when the result of unforeseen, urgent medical needs.

Providers furnishing certain services are excluded and cannot balance bill you with or without consent regardless of their specialty. (Those services can be defined as: emergency medicine, anesthesiology, pathology, radiology, neonatology, items and services provided by assistant surgeons, hospitalists, and intensivists, as well as diagnostic services (including radiology and laboratory services.

BENEFITS DESCRIPTIONS

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

It is important to see the Summary of Cost Sharing and Benefits section to determine if a healthcare service described in this section is a covered *benefit.* The Summary of Cost Sharing and Benefits section will also tell you the *cost sharing amounts* that you must pay to *providers* for covered *benefits*, and if any *benefit* limitations/maximums apply to the *benefit*.

Certain healthcare services require *preauthorization* by us or our designee. See the **Clinical Management Programs for Medical Benefits** section for more information.

Acute Care Hospital Room and Board and Associated Charges

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

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

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

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

Long-Term Acute Care Hospital (LTACH)

LTACH is an acute care *hospital* designed to provide specialized acute care for medically stable, but complex, patients who need long periods of hospitalization (average 25 days) and who would need high-intensity services. LTACHs are a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, the Pennsylvania Department of Health licenses LTACHs as an acute care facility.

Benefits for LTACHs include services provided when you are acutely ill and would otherwise require an extended stay in an acute care setting.

Acute Inpatient Rehabilitation

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

Allergy Services

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

Testing

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

Immunotherapy

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

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

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

Allergy Serums

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

Autism Spectrum Disorders

Benefits are provided for the diagnostic assessment and treatment of *autism spectrum disorders*. The applicable *cost sharing amount* for the type of service provided (e.g., therapy services, diagnostic services, etc.) as set forth in the **Summary of Cost Sharing and Benefits** section of this contract applies. However, any visit limits listed in the **Summary of Cost Sharing and Benefits** for the service will not apply when received for an *autism spectrum disorder* diagnosis.

Diagnostic Assessment

Diagnostic assessment to see if an individual has *autism spectrum disorder* consists of *medically necessary* assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner.

Treatment

Coverage for the treatment of *autism spectrum disorders* may include the following *medically necessary* services:

- Rehabilitative and Habilitative care - professional services and treatment programs, including *applied behavior analysis*, provided by an *autism service provider* to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

- Therapeutic care - services provided by a speech language pathologist, occupational therapist or physical therapist
- Psychiatric care - direct or consultative services provided by a physician who specializes in psychiatry.
- Psychological care - direct or consultative services provided by a psychologist.

Blood and Blood Administration

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

Diabetic Services, Supplies and Education

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

Equipment, agents, and orthotics include the following:

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

Diabetes Education

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

Diagnostic Services

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

Laboratory Tests

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

There may be an added *cost sharing amount* for lab services performed by a *provider* that is not an independent laboratory. An independent laboratory is one that performs clinical pathology procedures and is not affiliated or associated with a *hospital, physician or facility provider*. For a list of independent laboratories, and how to access them, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *ID card*. There may also be an added *cost sharing amount* for lab services performed by an independent laboratory if the independent laboratory opts to outsource some of the laboratory tests to another *provider*.

Medical Tests

Benefits for diagnostic medical tests include Electrocardiograms (EKG's), Electroencephalograms (EEG's), and other diagnostic medical procedures performed to diagnose or treat a disease or condition.

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

Radiology Tests

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

Other Diagnostic Tests and Services

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

Dialysis Treatment

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

Durable Medical Equipment (DME) and Supplies

Durable medical equipment consists of items that meet these criteria:

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

Examples of covered DME are wheelchairs, continuous positive airway pressure (CPAP) machines, 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 a covered DME only when the enteral nutrition is *medically necessary.*

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

DME may be rented or bought based on:

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

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

Except for risk of disability or death, there are generally no *benefits* for replacement DME when repairs are due to equipment misuse or abuse, or for replacement of lost or stolen items. Replacement due to change in employment, school or home settings are not eligible unless *medically necessary* due to change in health condition.

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 (e.g., post-surgical or wound care medical supplies). *Benefits* for medical supplies also include items such as hoses, tubes and mouthpieces that are *medically necessary* for proper functioning of covered DME.

Emergency and Urgent Care Services

Emergency Services

An *emergency service* is any healthcare service provided to you after the onset of a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any one of the following:

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

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

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

Inpatient hospital stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*. Observation status is not considered *inpatient* admission. Emergency room *cost sharing*

amounts will apply to observational care unless you are admitted as an *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient* consultation *copayment*.

When you receive *emergency services* from an *out-of-network provider*, *benefits* will be provided at the *in-network provider* level. You will need to pay any applicable *cost sharing amounts* such as *deductibles*, *coinsurance*, and *copayments*, and will not be liable for a greater out-of-pocket expense than if you had received the service from an *in-network provider*.

When *emergency services* are provided for the administration of the rabies vaccine series at the initial visit/injection, only one emergency copayment will apply. Additional nonemergency cost share may apply for any subsequent vaccine injections.

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

Urgent Care Services

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

Enteral Nutrition

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

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

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

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

Fertility Services

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

Benefits do not include artificial insemination services or other 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)

Gynecological Services

Screening Gynecological Exam

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

Diagnostic gynecological exams are covered under the **Office Visits, Consultations, Clinics, Telehealth Visits and VirtualCare** section and may be subject to *cost sharing amounts*.

Screening Papanicolaou Smear

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

Diagnostic pap smears are covered under the **Diagnostic Services** section and may be subject to *cost sharing amounts*.

Home Healthcare Services

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

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

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

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

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

Home Healthcare Visits Related to Mastectomies

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

Home Healthcare Visits Related to Maternity

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

Hospice Care

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

The *hospice provider* must bill all eligible *hospice* services.

Benefits for *hospice* care include the following services provided by a *hospice provider* responsible for your 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 for palliation or management of acute medical symptoms.
- *Inpatient* services of an acute medical nature arranged through the *hospice provider* in a hospital or skilled setting to address short-term pain and/or symptom control that cannot be managed in other settings.

Residential hospice care involves palliative care provided in a *hospice* facility for the express or implied purpose of providing end-of-life care for the terminally ill patient who is unable to remain in the home

and requires facility placement to provide for routine activities of daily living (ADLs) as well as specialized *hospice* care on a 24-hour-per-day basis.

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

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

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

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

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

Immunizations and Injections (Non-Preventive)

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

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

Infusion Therapy

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

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

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

Interruption of Pregnancy

Benefits for an interruption of pregnancy include, to the extent permitted by state law, 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.

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 available to an individual without signs or symptoms of breast disease, for the purpose of early detection of breast cancer. Screening mammograms are covered *benefits* and do not have any *cost sharing* when the service is performed by an *in-network provider. Benefits* for screening mammograms also include additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation, if indicated, to complete the screening process or to address findings on the initial screening mammography. More information is available under the **Preventive Care Services** section and the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Diagnostic Mammogram

A diagnostic mammogram is intended to provide specific evaluation of patients with a detected breast abnormality. *Benefits* for diagnostic mammograms may be subject to *cost sharing amounts*.

Maternity Services (Non-Preventive)

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

Prenatal Services

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

Delivery

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

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

provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, require that a *physician* or other healthcare *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *professional providers* or *facilities*, or to reduce *out-of-pocket* costs, you may be required to obtain *preauthorization*.

Postpartum Services

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

Medical Transport

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

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pickup is not accessible by land, and the transport is to an acute care hospital (whether for initial transport or subsequent transfer to another facility for special care). *Out-of-network* air emergency providers are prohibited from balance billing you.

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.

When you receive emergency ambulance services from *out-of-network providers*, *benefits* will be provided at the *in-network provider level*. You will need to pay any applicable *cost sharing amounts* such as *deductibles*, *coinsurance*, and *copayments*. Where emergency ambulance services cannot reasonably be provided by an *in-network provider*, you are not liable for a greater out-of-pocket expense than if you had received the service from an *in-network provider*.

Nonemergency Ambulance

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

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

Mental Health Services

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

Inpatient Services

Benefits for *inpatient mental health* services include bed, board and general *inpatient* nursing services when provided for the treatment of *mental illness*. Services provided by a *professional provider* to you as an *inpatient* for *mental health* 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* services include the *outpatient* treatment of a *mental illness* in a planned therapeutic program during the day only or during the night only.

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

Outpatient Services

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

Newborn Care

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

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

Nutrition Therapy (Counseling and Education)

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

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

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

Office Visits, Consultations, Clinics, Clinics, and Telehealth Visits

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

- *Telehealth* (audio and/or video)
- Provider office
- *Hospital*
- Retail clinic

Visits

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

Outpatient – *Benefits* for *outpatient* evaluation and management include *outpatient* visits provided by a *physician* or other *professional provider* for the prevention, diagnosis, and treatment of an injury or illness.

In certain situations, a facility fee may be associated with an *outpatient* visit to a *professional provider* where the *provider* bills separately for the *member's* use of that facility. *Members* should ask the *provider* of the service if a facility fee applies. An additional *cost sharing amount* may apply to the facility fee.

Consultations

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

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

Coverage for consultations does not include the following:

- Staff consultations required by *hospital* rules and regulations;
- Staff consultations related to teaching interns and resident medical education programs; and
- Consultations not provided directly to the *member*.

Outpatient – *Benefits* for *outpatient* consultations include *outpatient* office consultation visits between a *member* and a *physician*.

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 licensed or certified associated physician or allied health professional practicing within the scope of his/her licensure, certification or specialty. Retail clinic services are performed in an ambulatory medical clinic that provides a limited scope of services for preventive care or the treatment of minor injuries and illnesses. The clinic is open to the public for walk-in, unscheduled visits during all open hours, and offers significant extended hours, which may include evenings, holidays and weekends.

Telehealth Visits

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

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

Telehealth coverage does not include the following:

- Email communications for reporting or discussions of laboratory or other diagnostic and screening results
- Nurse call centers/advice centers
- Services involving remote invasive treatment and/or diagnostic testing
- Group counseling

Orthotic Devices

An orthotic device is a rigid or semi-rigid support. It 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. 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.

Preventive Care Services

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

Pediatric

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

Adult

Benefits for adult preventive care include routine physical examinations, immunizations, and tests. *Benefits* also include specific women's preventive services as mandated by law such as breastfeeding support, counseling and supplies (e.g. breast pumps). For more information, see the **Schedule of Preventive Care Services** attachment.

Services that need to be performed more often than stated in the **Schedule of Preventive Care Services** attachment due to high-risk situations are covered when the diagnosis and procedures are otherwise covered. We follow guidelines set by the CDC in determining high-risk individuals. These services are subject to all applicable *cost sharing amounts*.

Private Duty Nursing

Benefits for private duty nursing include services provided by an actively practicing registered nurse or a *licensed practical nurse* when ordered by a *physician* provided that such nurse does not ordinarily reside in the *member's* home or is not a member of the *member's* immediate family and that *Capital* concurs with the *physician's* certification that the care is *medically necessary*.

Prosthetic Appliances

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

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

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

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

Skilled Nursing Facility

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

Substance Use Disorder Services

Detoxification - Inpatient

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

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

Rehabilitation

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

Inpatient — *Benefits* for *inpatient substance use disorder* treatment include: bed, board and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to you as an *inpatient* for *substance use disorder* treatment is also covered.

Benefits also include treatment received at a *residential treatment facility* when preauthorized and *medically necessary*.

Outpatient — *Benefits* for *outpatient substance use disorder* treatment include services that would be covered on an *inpatient* basis but are otherwise provided for *outpatient,* in an *intensive outpatient treatment program (IOP)*, *partial hospitalization*, *medication assisted treatment (MAT)* or through an *opioid treatment program* (OTP).

Surgery

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

Surgical Procedure

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

Outpatient Surgery

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

Anesthesia Related to Surgery

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

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

Mastectomy and Related Services

A mastectomy is the surgical removal of all or part of a breast. *Benefits* for a mastectomy include a mastectomy performed on an *inpatient* or *outpatient* basis and *surgery* performed to reestablish symmetry or alleviate *functional impairment*, including, but not limited to augmentation, mammoplasty,

reduction mammoplasty and mastopexy. *Reconstructive surgery* to reestablish symmetry is covered for the unaffected breast as well as the affected breast. *Benefits* are also provided for physical complications due to the mastectomy such as lymphedema.

Oral and Orthognathic Surgery

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

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

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

Other Surgeries

Benefits for other specialized surgical procedures include the following services:

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

Therapy Services

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

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

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

Cardiac Rehabilitation Therapy

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

Maintenance cardiac rehabilitation therapy is not covered.

Chemotherapy

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

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

Manipulation Therapy

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

Benefits include maintenance manipulation therapy for chronic pain management.

Occupational Therapy

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

Benefits for occupational therapy include rehabilitative and habilitative services.

Physical Therapy

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

Benefits for physical therapy include rehabilitative and habilitative services.

Radiation Therapy

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

Respiratory/Pulmonary Rehabilitation Therapy

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

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

Maintenance respiratory and pulmonary therapy is not covered.

Speech Therapy

Benefits for speech therapy include those services necessary for the evaluation, diagnosis, and treatment of certain speech and language disorders (e.g., childhood stuttering) as well as services needed for the diagnosis and treatment of swallowing disorders.

Benefits for speech therapy include rehabilitative and habilitative services.

Transplant Services

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

Pre-Transplant Evaluation

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

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

Acquisition and Transplantation

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

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

Other Services

Contraceptives

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

Diagnostic Hearing Services

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

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

Foot Care

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

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

Orthodontic Treatment of Congenital Cleft Palates

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

Routine Costs Associated with Approved Clinical Trials

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

Vision Care for Illness or Accidental Injury

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

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

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

EXCLUSIONS

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

Anesthesia	• Anesthesia when administered by the assistant to the operating *physician* or the attending *physician*
Blood and Administration	• Prophylactic blood, cord blood or bone marrow storage to be used in case of an accident or unforeseen *surgery* or transplant
Clinical Trials	• Services or supplies that we consider to be *investigational*, except *routine costs associated with* a*pproved clinical trials* Routine costs for clinical trials do not include any of the following and are therefore excluded from *coverage*: o The *investigational* drug, biological product, device, medical treatment, or procedure itself, unless otherwise covered under an agreement between a *provider* and *Capital* (or other Blue plan) o Items and services that are provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient o Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis o Services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial o Your travel expenses
Convenience	• Personal hygiene, comfort, or convenience items such as, but not limited to: o Air conditioners, humidifiers, air purifiers and filters o Physical fitness or exercise equipment (including, but not limited to inversion, tilt, or suspension device or table) o Radios and televisions o Beauty or barber shop services o Incontinence supplies, deodorants o Guest trays, chairlifts, elevators, or any other modification to real or personal property, even if recommended by a *provider* o Spa or health club memberships o Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments such as premiums, which entitle those enrolled to services; repairs; or replacement of devices, equipment, or parts without charge or at a reduced charge
Cosmetic Surgery	• Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the

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

	adhesive removers, face masks, replacement batteries or alcohol pads • Supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices
Education	• Services provided at unapproved sites, for a *member*'s individualized education program (IEP), or as part of a *member's* education, except as may be required by statue or explicit legal requirement
Eligibility	• Services incurred prior to your *effective date of coverage* • Services incurred after your *coverage* termination date except as provided for in this *Benefits Booklet*
Eligible Provider	• Services not billed and either performed by, or under the supervision of, an eligible *provider* • Services provided by a *provider* who is a member of your *immediate family* • 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* • Services from *providers* that are excluded or debarred from government plans
Experimental or Investigational	• Services or supplies we consider to be *investigational,* except where otherwise required by law
Fertility Services	• Donor services related to assisted fertilization • Any treatment or procedure leading to or in connection with assisted fertilization, such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and artificial insemination except as provided in this *Benefits Booklet* • For fertility 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
Food/ Nutritional Support	• Enteral nutrition due to lactose intolerance or other milk allergies • Blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Benefits Booklet* • All other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Benefits Booklet*

Foot Care	• Routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone *surgery*), toe nails (except *surgery* for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints • 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
Genetic Testing	• At-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic testing performed primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*
Hearing Aids	• *Hearing aids*, examinations for the prescription or fitting of *hearing aids*, and all related services
Immunizations	• Immunizations required for travel or employment except as required by law • Immunizations administered at a pharmacy are not eligible under the medical benefit
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Services not permitted by state law • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by our Medical Director(s) or his/her designee(s)
Medicare	• Items or services to the extent paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws for any *member* who is enrolled in *Medicare*. This exclusion does not apply to the extent the *contract holder* is required by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare*.
Medications	• All prescription and *over-the-counter* drugs dispensed by a pharmacy or *provider* for your *outpatient* use, whether or not billed by a *facility provider*, except for allergy serums, mandated pharmacological agents used for controlling blood sugar, FDA-approved drugs for the treatment of substance use disorder, and where otherwise required by law

	• All prescription and *over-the-counter* drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan that we approved
Military Services	• Services received by veterans and active military personnel at facilities run by the U.S. Department of Veterans Affairs or by the Department of Defense, unless payment is required by law
Miscellaneous	• Care of conditions that federal, state, or local law requires to be treated in a public facility • Any services received while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • Services you receive from a dental or medical department maintained by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar person or group • Charges for: failure to keep a scheduled appointment with a *provider*, completion of a claim or insurance form, obtaining copies of medical records, your decision to cancel a *surgery*, or hospital-mandated on-call service • Charges that exceed the *allowed amount*, except as otherwise provided for in this *Benefits Booklet* • *Cost sharing amounts* you must pay as outlined in this *Benefits Booklet* • Autopsies or any other services performed after a *member's* death • Any services related to or performed in connection with a noncovered service, including but not limited to anesthesia and diagnostic services • Routine examination, counseling services, testing, screening, immunization, treatment or preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to: pre-marital examinations; employment or occupational screenings, physicals for college, camp, sports, or travel • Community support services or programs, including but not limited to community-based wrap-around services, self-help/peer support, community integration support, employment support, psychoeducational services, mental clubhouses, and outreach services
Motor Vehicle Accident	• Cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy
Oral Surgery	• Oral *surgery* except as specifically provided in this *Benefits Booklet*
Prosthetics	• Prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device

	• Wigs and other items intended to replace hair loss due to male or female pattern baldness
Sexual Dysfunction	• Treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury
Sports Medicine	• Sports medicine treatment or equipment intended primarily to enhance athletic performance
Surgery	• All types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present • For treatment or procedures leading to or in connection with transsexual surgery or transgender reassignment surgery except for sickness or injury resulting from such surgery or for the surgical treatment of congenital ambiguous genitalia present at birth
Therapy Services	• For acupuncture • Applied behavior analysis therapy services provided for any diagnoses other than *autism spectrum disorders* • Other biofeedback therapy • Maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law • Occupational therapy or physical therapy for work hardening, vocational and prevocational assessment and training, and functional capacity evaluations, as well as this therapy's use towards enhancement of athletic skills or activities • All rehabilitative therapy, other than as described in the *Benefits Booklet*, including but not limited to play, music, hippotherapy, and recreational therapy
Temporomandibular Joint Disorder	• Treatment of temporomandibular joint disorder (TMJ) including, but not limited to *surgery*, intra-oral devices, splints, physical therapy, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ or treatment of TMJ caused by physical trauma resulting from an accident • Intra-oral removable prosthetic devices or appliances regardless of the cause of TMJ
Transplant	• Services related to organ donation where you serve as an organ donor to a nonmember • Transplant services where human organs were sold rather than donated and for devices functioning as total artificial organs that are not approved by the FDA
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this

	Benefits Booklet
Vision Care	• Routine eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to refractive lenses prescribed for use with an intra-ocular lens transplant • Routine vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses. • Surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy, and refractive keratoplasty
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared. • War is a hostile conflict by armed forces, carried on between countries, states or rulers, or sometimes between political communities within the same country or state. An act of terrorism is not an act of war. Terrorism is the use of threat of violence to intimidate or cause panic, especially as a means of achieving a political end.
Weight Loss	• *Inpatient* stays to bring about weight reduction
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy or coverage, or the applicable law.

CLINICAL MANAGEMENT PROGRAMS FOR MEDICAL BENEFITS

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

Clinical Management programs include:

- Utilization Management
- Population Health Management
- Quality Improvement

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

Utilization Management

The purpose of the Utilization Management (UM) Program is to ensure that high quality, cost-effective, and medically appropriate services are provided to *members* through a comprehensive framework in accordance with applicable *coverage* terms and conditions, regulatory and accreditation requirements. The UM program includes *Preauthorization*, Concurrent Review and Retrospective Review.

Medical Necessity Review

Your *coverage* provides *benefits* only for services we, or our designee, decide are *medically necessary*.

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

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

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

Even if an *in-network provider* recommends that you receive services from an *out-of-network provider*, you will need to payor all services we decide are not *medically necessary*.

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

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

Investigational Treatment Review

Your *coverage* does not include services we decide are *investigational*.

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

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

Preauthorization

Medical Services Requiring Preauthorization

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

- Medically appropriate treatment to meet individual needs and
- Care from *in-network providers* delivered in an efficient and effective manner.

For services that need to be preauthorized, the *in-network provider* is responsible for obtaining the *preauthorization*. Also, BlueCard® facility providers that perform inpatient services must get those inpatient services preauthorized.

Out-of-network providers and BlueCard providers performing non-inpatient services may ask for *preauthorization* for you. However, if you are seeing one of these *providers*, you are ultimately responsible for getting the required approval before you receive the service.

You or your *provider* can call us toll-free at 1.800.730.7219 to ask for a *preauthorization*. *In-network providers* should use the provider portal to ask for *preauthorization*. Out-of-network and out-of-area providers can go to CapitalBlueCross.com to learn how to ask for *preauthorization*.

Preauthorization approvals do not guarantee payment. Payment depends on your *benefits* and eligibility on the date of service. See the Single Source Preauthorization List on CapitalBlueCross.com for a complete list of services that currently need preauthorization. We may change this list from time to time.

Requests for admissions and services that are not urgent should be made well before the scheduled date of service. A decision will be made within 15 days of when we get all the information we need. You or your *provider* can read our medical policies at CapitalBlueCross.com or may contact us to see if we believe a service is *investigational*. *Investigational* procedures are not covered *benefits*.

Preauthorization for Care that is Needed Urgently

You or your *provider* must tell us when a *preauthorization* request involves urgent medical circumstances to be treated as an urgent request. We will respond to an urgent request no later than 72 hours after we get all the information needed to make a decision.

If the request is to continue health care services you are already receiving, the request must be made at least 24 hours before the current treatment reduces or ends. We will respond within 24 hours after we get all the information needed to make a decision.

Emergency Services and Non-routine Maternity Admission

Services provided by an emergency department do not need to be *preauthorized*. However, we must be notified within two business days of an inpatient admission that was because of an emergency department visit. The services will be reviewed and must meet medical necessity criteria from the first hour of admission. An administrative denial could happen if we are not notified of the admission.

Emergency diagnostic services do not require *preauthorization* when performed during an emergency room visit, observation stay, or inpatient admission.

We must be notified about non-routine maternity admissions, including preterm labor and maternity complications, within two business days of the admission.

Failure to Get Preauthorization

Not getting *preauthorization* for a service could mean the *provider's* payment is reduced or denied. Your *benefit* could also be reduced or even denied. We may do a retrospective *medical necessity* review if a service is not *preauthorized*.

If you show your *ID card* to an i*n-network provider* in our 21-county area and that *provider* does not get or does not follow *preauthorization* requirements, payment for services will be denied. The *provider* may not bill you for the services performed.

Concurrent Review Program

The Concurrent Review program includes concurrent review and discharge planning.

Concurrent Review – Experienced clinicians and board-certified physicians conduct concurrent reviews. They 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 helps to identify and refer *members* to other Clinical Management programs to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning. A concurrent review decision is generally issued within one day of receiving all necessary information.

The UM program also includes concurrent review for select outpatient services. The outpatient concurrent review process involves the review of care and services received, consumption of resources, current clinical status, and progress experienced while treatment is being delivered. This process allows for modification of treatment plans to align with the clinical picture and ensure continued medical necessity requirements are met. A concurrent review decision for nonurgent requests for an outpatient service is issued within fifteen (15) calendar days of receiving all necessary information.

Discharge Planning – Concurrent review clinicians also perform discharge planning. They communicate with hospital staff 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.

Retrospective Review

Our clinicians conduct retrospective review through the review of medical records to determine whether the care and services provided and submitted for payment were *medically necessary*. Retrospective review is performed when we receive a claim for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred any of the following ways:

- Under *coverage* that does not include the *preauthorization* program.

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

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

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

Population Health Management

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

Care Management

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

Programs include, but are not limited to the following:

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

Complex Case Management

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

- With complex medical needs. Complex medical needs require more support to respond to the *member's* health or medical needs requiring enhanced medical oversight.
- At risk for future adverse health events, which may include *hospital* admission or readmission.
- Identified with Social Determinants of Health (SDoH) barriers. SDoH barriers can impede one's health, well-being, and safety; examples include, but are not limited to, risk of eviction, access to health meals, and transportation barriers.

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

Chronic Condition/Disease Management

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

The goal of chronic condition management is to improve:

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

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

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

High Risk Maternity Management

We offer a comprehensive high risk maternity management program that provides care coordination, educational materials and support to pregnant women in all phases of pregnancy and delivery, including high-risk labor and delivery, newborn care and post-partum care.

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

Oncology Case Management

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

Transitions of Care

This program helps *members* in understanding their post-discharge treatment plan and thereby helps prevent avoidable complications and readmissions.

Transplant Case Management

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

Health Education and Wellness

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

Care Navigation and Advocacy

We provide *member*-specific care navigation and advocacy services including but not limited to:

- Answering questions about enrollment and *coverage*.
- Assisting with transfers to care management, as needed, for chronic conditions and acute healthcare needs.
- Providing access to health and wellness tools that help tobacco cessation, nutrition or stress management.
- Providing access to decision-support tools and access to a Symptom Checker to help you can make informed choices for your lifestyle and healthcare needs.

Quality Improvement Program

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

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

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

How We Evaluate New Technology

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. We strive to be knowledgeable about recent medical developments and best practice standards to keep our medical policies up-to-date. *Capital's* Medical Policy and Coding department coordinates the adoption of new *medical necessity* policies and the annual review of Capital's existing *medical necessity* policies. Various *Capital* committees evaluate the use of new medical technologies and new applications of existing technologies and provide opportunity for multidisciplinary group review, discussion, and final approval. These committees may include internal staff, including clinicians, pharmacists, and medical directors of various specialties, and external physicians who can act as subject matter experts and provide clinical input on *medical necessity* policy position. External independent physician reviewers may also be used.

Through these committees, Capital reviews topics such as the effectiveness and safety of new technology in treating various conditions along with any associated risks. Five criteria are used to evaluate new technology including:

1. The technology must have final approval from the appropriate governmental regulatory bodies.

2. The scientific evidence must allow conclusions concerning the effect of the technology on health outcomes.
3. The benefits of the technology must outweigh any likely harmful effects such that the net health outcome is improved.
4. The technology must be as beneficial as any established alternatives.
5. The improvement in net health outcomes must be attainable outside an *investigational* setting.

A variety of sources are referenced including technology evaluation bodies, current medical literature, national medical associations, specialists and professionals with expertise in the technology, and governmental agencies such as the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC).

Following comprehensive review, evaluation and discussion on the new technology and after assessing member and provider impact, final decisions on *medical necessity* policies are made.

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

Alternative Treatment Plans

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

If the *contract holder* elects to provide alternative *benefits* in one instance, it does not obligate the *contract holder* to provide the same or similar *benefits* 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

To be considered a *subscriber*, child, or *dependent* under this *coverage*, 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 ASK THE CONTRACT HOLDER WHAT SPECIFIC TIME FRAMES ARE APPLICABLE TO THEM.

SUBSCRIBERS WHO FAIL TO SUBMIT AN ENROLLMENT APPLICATION WITHIN THESE SPECIFIC TIME FRAMES 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 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 us in advance of the *effective date of coverage*.

Nondiscrimination

We 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, or sex; or (iii) health status-related factors pertaining to the *subscriber* or *member*. Factors include health status, medical condition, claims experience, receipt of healthcare, 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 us 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 completing 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.

We reserve the right to require documentation confirming marriage to the *subscriber*, including, but not limited to, a marriage certificate, court order or joint statement of common law marriage.

Dependent - Domestic Partner

- To enroll in this *coverage* as a *dependent* domestic partner, an individual must be in a relationship with another adult partner of the same or opposite sex, and who live together and share a domestic life, but are not married or joined by a civil union.

We reserve the right to request documentation that confirms the domestic partnership prior to commencing *coverage* for the domestic partner.

Child

To enroll under this *coverage* as a child, an individual must be under the age of 26 and meet one of the following criteria:

- A birth child of the *subscriber,* the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A child legally adopted by or placed for adoption with the *subscriber,* the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A ward (a child for whom the *subscriber,* the *subscriber's* spouse, or the *subscriber's* domestic partner has been granted legal custody by a court of competent jurisdiction).
- A child for whom the *subscriber,* the *subscriber's* spouse, or the *subscriber's* domestic partneris required to provide healthcare coverage pursuant to a Qualified Medical Child Support Order (QMCSO).

Dependent - Child Age 26 or Older with a Disability

An individual must be an unmarried child age 26 or older to enroll as a *dependent* child with a disability. The child must meet all of the following:

- A birth child, adopted child, or ward of the *subscriber,* the *subscriber's* spouse or the *subscriber's* domestic partner.
- Mentally or physically incapable of earning a living; or unable to engage in self-sustaining employment because of any medically determinable physical or mental impairment(s) which has lasted or can be expected to last for a continuous period of not less than 12 months.
- Chiefly dependent upon the *subscriber,* the *subscriber's* spouse, or the *subscriber's* domestic partner for support and maintenance, provided that:
  - The incapacity began before age 26,
  - The *subscriber* provides us with proof of incapacity within 31 days after the *dependent* child with a disability reaches age 26, and
  - The *subscriber* provides updated information if requested by us, 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.

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

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

To qualify for this extension of eligibility, the child or *subscriber* must provide to us 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 of the following:

- 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.

To qualify for this extension of eligibility, the child must send the following forms to us:

- 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 you "enroll" with us, you agree to participate in a contract for *benefits* between the *contract holder* and us. All qualified requests to enroll or to change enrollment must be made through the *contract holder*.

Every *member* must complete and submit to us, 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 ask the *contract holder* for the specific timeframes applicable to their *coverage*.

We will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to 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 us.

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 *coverage* with us 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 above. 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 us or as provided by law.

Subscriber

A new *subscriber* may enroll 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 ask the *contract holder* for the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Dependent - Newborns

For 31 days following birth, a *member's* newborn child is covered under this *coverage*.

An eligible newborn **must** be enrolled as a *dependent* under the *group contract* or enrolled under a separate contract, within 31 days of birth to have ongoing *coverage*. If the newborn child qualifies as a *dependent* under the *group contract*, you must notify the *contract holder* immediately and an 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*. Refer to the **Timelines for Submission of Enrollment Applications** section 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.

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 the following:

- A change in job status.
- A change in marital status.
- A change in domestic partnership.

- The birth, adoption, or placement for adoption of a child.
- Acquiring a stepchild or becoming a legal guardian for a child.
- A court order.
- A change in *Medicare* status.
- A change in the status of other insurance.
- Loss of other minimum essential coverage, including but not limited to the following:
  - A loss due to termination of employment or reduction in hours.
  - Divorce or legal separation.
  - Relocation outside our *service area*.
  - A child ceasing to be eligible for *coverage* under the *group contract*.

If one of these events occurs, you must notify the *contract holder* immediately. To enroll for *coverage*, *members* must enroll within the required timeframe after the date of the applicable event noted above (or in the case of a ward for a child, the date specified in the legal custody order).

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*. Refer to the **Timelines for Submission of Enrollment Applications** section above for more details.

Group Enrollment Period

During a *group enrollment period*, you may make healthcare coverage changes, if applicable, and add eligible *dependents* previously not enrolled. A *group enrollment period* occurs at least once annually.

Effective Date of Coverage

Initial and Newly Eligible Members

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

Life Status

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

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

  The date of attaining eligibility as a domestic partner.
- The first date after loss of other health insurance coverage.
- First day of the month following enrollment after an individual loses other minimum essential coverage.

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

TERMINATION OF COVERAGE

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

Termination of Group Contract

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

Termination of Coverage for Members

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

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

- *Subscriber* – *Coverage* ends on the date a *subscriber* is no longer employed by, or a member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for the *subscriber's dependents* is also terminated.
- *Dependent* Spouse – *Coverage* of a *dependent* spouse ends on the date the *dependent* spouse ceases to be eligible under this *coverage*.

  Dependent Domestic Partner – *Coverage* of a *dependent* domestic partner ends on the date the *dependent* domestic partner ceases to be eligible under this *coverage.*
- Child – *Coverage* of a child ends on the date the child is no longer eligible as described in the **Membership Status** section.
- *Dependent* Child Age 26 or Older with a Disability – *Coverage* of a *dependent* child age 26 or older with a disability ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* child with a disability.

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

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

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as

provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination.

CONTINUATION OF COVERAGE AFTER TERMINATION

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

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

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 include, but are not limited to the following:

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

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

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

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

Coverage for Medicare-Eligible Members

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

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

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

Coverage for Totally Disabled Members

Benefits will be provided to a totally disabled *subscriber* or a totally disabled *dependent* for services **directly related** to the condition that caused this total disability and for no other condition, illness,

disease, or injury if the *subscriber* or the *dependent* is totally disabled on the date *coverage* is terminated.

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

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

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

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

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

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

CLAIMS REIMBURSEMENT FOR MEDICAL BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for healthcare services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services or supplies are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which *we* receive a claim for *benefits* is dependent upon the type of *provider* from which you receive services.

In-Network Providers

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

Out-of-Network Providers

If you visit an *out-of-network provider*, the *provider* may require you to pay for the service when it is provided. Although *out-of-network providers* may file claims on your behalf, they do not have to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Unless we agreed or are required by law to pay the *out-of-network provider* directly, payment for services provided by an *out-of-network provider* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made. However, we will make payment directly to the *out-of-network provider* for *emergency services*, air ambulance services, or non-*emergency services* received at an in-network hospital, hospital outpatient department, critical access hospital, or *ambulatory surgical facilities*.

Out-of-Area Providers

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

Allowed Amount

The *benefit* payment is based on the *allowed amount* on the date the service is provided, except as otherwise required by law.

Benefit payments to *hospitals* or other *facility providers* may be adjusted from time to time based on settlements with such *providers*. These adjustments will not affect the *cost sharing amounts* that you must pay.

Filing a Claim

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

You can get a claim form at CapitalBlueCross.com or call Member Services at the number found on the back of your *ID card*. Your claim will process more quickly when the form is used. A separate claim form must be completed for each *member* who received medical services.

A Special Note about Medical Records

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

Where to Submit Medical Claims

Send your claims with a completed Capital Blue Cross Medical Claim Form and an itemized bill to:

Capital Blue Cross
PO Box 211457
Eagan, MN 55121

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

Out-of-Country Claims

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

Inpatient Hospital Claims

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

Professional Provider Claims

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

International Claim Form

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

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

All claims must be submitted within 12 months from the date of service, except for claims from certain state and federal agencies.

Time Frames Applicable to Medical Claims

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

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

We may extend the 15 or 30 day period one time for up to 15 days for circumstances beyond our control. We will let you know before the end of the original time period if we need an extension. We both may also agree to an extension if either of us needs more time to obtain information necessary to process the claim.

Special Time Frames Applicable to "Urgent Care" Claims

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

We will let you know of the decision on an urgent care claim as soon as possible but no later than 72 hours after receipt of the claim, unless we need more information to make a determination of coverage.

If that is the case, we will let you know the additional information that is needed within 24 hours after we receive the claim.

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

Special Time Frames Applicable to "Concurrent Care" Claims

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

If you believe that any delay in extending the period of time or number of treatments would jeopardize your life, health, or ability to regain maximum function, you must request an extension at least 24 hours before the end of the prescribed period of time or number of treatments. You must request an extension by calling Member Services at the number listed on the back of your *ID card*. We will review your request and let you know our decision within 24 hours after we receive the request.

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

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

Coordination of Benefits (COB)

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

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

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

Definitions Unique to Coordination of Benefits

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

Plan: Means This Coverage and/or Other Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

   a. Nondependent or Dependent.

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

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

   b. Child Covered Under More Than One Plan.

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

      (i) For a child whose parents are married or are living together:

      - 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:

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

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or coverage of the child, the provisions of Subparagraph (i) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's healthcare expenses or coverage, the order of benefits for the child is as follows:
  - The Plan covering the Custodial Parent;
  - The Plan covering the spouse of the Custodial Parent;
  - The Plan covering the noncustodial parent; and then
  - The Plan covering the spouse of the noncustodial parent.

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

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

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

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

d. *COBRA* or State Continuation Coverage.

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

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

e. Longer or Shorter Length of Coverage.

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

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

Effect on the Benefits of This Coverage

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

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

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

Right to Receive and Release Needed Information

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

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

Facility of Payment

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

Right of Recovery

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

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

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

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

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

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

Disability

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

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

End Stage Renal Disease (ESRD)

The *group contract* will pay primary for the first 30 months of a *member's* eligibility or entitlement to *Medicare* due to ESRD, as defined under applicable *Medicare* statutes. Upon the expiration of this 30 month period: (1) if the member is enrolled in *Medicare* due to ESRD, the *group contract* will pay benefits as secondary to *Medicare* for so long as the member remains enrolled, and (2) if the *member* is eligible for, but to *Capital's* knowledge has not enrolled in, *Medicare* due to ESRD, the *group contract* will remain primary to *Medicare*. However, if the *group contract* is currently paying *benefits* as secondary to *Medicare* for a *member*, the *group contract* will remain secondary upon a *member's* entitlement to *Medicare* due to ESRD.

Retirees

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

Third Party Liability/Subrogation

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

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

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

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

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

Third Party Liability

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

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

Workers' Compensation Insurance

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

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

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

Motor Vehicle Insurance

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

Assignment of Benefits

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

Payments Made in Error

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

APPEAL PROCEDURES

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

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 a decision by us that, based upon the information provided and upon application of utilization review, a request for a benefit does not meet our requirements for *medical necessity* and appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or *investigational*, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit. A rescission of *coverage* is also an adverse benefit determination.

Internal Appeal Process

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

Capital Blue Cross
PO Box 779518
Harrisburg, PA 17177-9518

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

In reviewing the appeal, we will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination. You may contact us at **800.962.2242** (TTY: **711**) to receive information on the internal review process and to receive additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al **800.962.2242**.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you, in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

External Appeal Process

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on our requirements for *medical necessity*, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission) or the special rules applicable to out-of-network emergency services, air ambulance services, and other (nonemergency) services received at certain in-network facilities.

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

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

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

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit determination*s* involving "urgent care decisions".

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

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

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

How to Appeal a Concurrent Care Claim Determination

Special rules apply to adverse benefit determination*s* involving "concurrent care decisions".

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

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

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

Designating an Individual to Act on Your Behalf

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

To name an individual to serve as your *authorized representative* you must complete, sign, date, and return *Capital's* Authorization of Designated Appeals Representative (ADAR) Form. You may request this form from our Member Services department at **800.962.2242** (TTY: **711**) or obtain a copy on the CapitalBlueCross.com website.

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

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

- An insured arrangement, we are the named fiduciary.
- A self-funded or "self-insured" arrangement, either we 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 a *member* is entitled to receive *benefits* under the terms of the group health plan. Any construction of terms of any plan document and any determination of fact adopted by the named fiduciary will be final and legally binding on all parties, subject to review only if such construction or determination is arbitrary, or capricious, or otherwise an abuse of discretion.

GENERAL PROVISIONS

Additional Services

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

Discounts and Incentives

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

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

Benefits are Nontransferable

No person other than a *member* is entitled to receive *benefits* under the *group contract*. Such right to *benefits* is not transferable.

Changes

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

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

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

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

Discretionary Changes by Capital

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

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

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

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

Conformity with Statutes

The parties recognize that the *group contract* 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.

If 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* shall remain in full force and effect.

Choice of Forum

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

Choice of Law

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

Choice of Provider

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

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

Clerical Error

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

Entire Contract

The *group contract* sets forth the terms and conditions of *coverage* offered 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*. The *group contract* is made up of four different documents: the *group* policy/*contract,* the *group application,* the *enrollment applications*, and this *Benefits Booklet*. If there is a conflict of terms between the *group* policy/*contract* and the *Benefits Booklet*, the terms of the *group* policy/*contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

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

Failure to Perform Due to Acts Beyond Capital's Control

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

Gender

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

ID Cards

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

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

Legal Action

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

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

Notices

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

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

Proof of Loss

Claims for proof of loss must be submitted within 12 months after completion of the covered services to receive benefits from *Capital*. *Capital* will not be liable under this *group contract* unless proper and prompt notice is furnished to *Capital* that covered services have been rendered to a *member*. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the **Summary of Cost Sharing** section. The claims must include the data necessary for *Capital* to determine benefits. An expense will be considered incurred on the date the service or supply was rendered. Claims should be sent to:

Capital Blue Cross
PO Box 211457
Eagan, MN 55121

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

Time of Payment of Claims

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

Member's Payment Obligations

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

Payments

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

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

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

Payment Recoupment

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

Policies and Procedures

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

Relationship of Parties

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

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

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

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

Waiver

Our failure or delay in enforcing any provision of the *group contract* does not constitute, and shall not be deemed or construed to be a waiver of the enforceability of such provision or of any other provisions of the *group contract*. Further, any failure or delay in enforcement of any provision shall not prohibit the future enforceability of any such provisions. Similarly, our 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 remedy. Moreover, payment of a claim at *Capital's* discretion does not waive our right to deny payment or *coverage* for the reasons specified in the *group contract*.

Waiver of Liability

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

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

Public Health Emergency

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

Physical Examination and Autopsy

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

ADDITIONAL INFORMATION

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

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

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

Capital Blue Cross
PO Box 779519
Harrisburg, PA 17177-9519

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

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

For Products issued by:
Capital Advantage Assurance Company®
Subsidiary of Capital Blue Cross

Capital

2026 Schedule of Preventive Care Services

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 (HHS), 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 years and older

GENERAL HEALTHCARE*		
For routine history and physical examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer Chemoprevention • Contraceptive Methods/Counseling[1] • Folic Acid (childbearing age)	• Hormone Replacement Therapy (HRT) – Risk vs. Benefits • Urinary Incontinence Assessment	At least annually
Men and Women		
• Aspirin Prophylaxis (high-risk) • Drug Use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity/Exercise • Seat Belt Use • Statin Medication (high-risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) Test	Age 65 and older, test every 2 years. Age 19-64, test if postmenopausal and at risk for osteoporosis.
BRCA Screening/Genetic Counseling/ Testing	BRCA screening and counseling if at risk and not previously diagnosed with BRCA-related cancer and who have a personal or family history of cancer. BRCA testing once per lifetime if recommended by your healthcare provider.
Domestic/Intimate/Partner Violence Screening and Support	Age 19 and older: Screening annually and offer support services as determined by your healthcare provider.
Mammogram (2D or 3D)	Beginning at age 40 (under age 40 based on provider recommendation), every 1-2 years for women at average risk for breast cancer. Includes additional imaging (MRI, ultrasound) and patient navigation services, as determined by your healthcare provider.
Obesity in Midlife Women	Age 40-60 with normal to overweight body mass index (BMI), offer counseling to prevent obesity.
Pelvic Exam/Pap Smear/HPV DNA	Pelvic Exam/Pap Smear: Age 21-65: every 3 years; HPV DNA: Age 30-65, every 5 years. Offer patient navigation services, as determined by your healthcare provider.
Men	
Abdominal Aortic Aneurysm Screening	Age 65-75, one-time screening for abdominal aortic aneurysm in men who have ever smoked.
Prostate Cancer Screening	Beginning at age 50, annually. Begin at age 19 for high-risk males.
Prostate Specific Antigen	Beginning at age 50, annually.
Men and Women	
Alcohol Use Screening/Counseling	Age 19 and older: Offer behavioral counseling interventions for adults who are engaged in risky or hazardous drinking.
Anxiety/Depression Screening	Age 19 and older: Annually or as determined by your healthcare provider.
Cardiovascular Disease Prevention	Age 19 and older at increased risk of cardiovascular disease (CVD); screening and offer behavioral counseling.
Chlamydia and Gonorrhea Test	Age 19-24 years, test all sexually active women and 25 years and older test based on individual risk and recommendation by your healthcare provider. Test as recommended when prescribed HIV PrEP.
CT Colonography[2]	Beginning at age 45, every 5 years.
Colonoscopy[3]	Beginning at age 45, every 10 years.
Diabetes Screening	Age 35-70, screening tests in primary care settings if overweight or obese (with a BMI of 25 or greater). If normal, rescreen every 3 years. Offer prevention interventions, as determined by your healthcare provider.
Fasting Lipid Profile	Beginning at age 20, every 5 years.
Fecal Occult Blood Test (gFOBT/FIT)[4]	Beginning at age 45, annually.
FIT-DNA Test	Beginning at age 45, every 1-3 years.
Flexible Sigmoidoscopy[3]	Beginning at age 45, every 5 years.
Hepatitis B Test	Age 19 and older if at high risk. Periodic repeat testing with continued risk factors.
Hepatitis C Test	Age 19 and older, offer one-time testing. Periodic repeat testing with continued risk factors.
High Blood Pressure (HBP)	Age 19-39, testing every 3-5 years with no other risk factors. Age 40 and older, or younger if at increased risk, test annually.

HIV PrEP Medication with related Testing/Counseling	If prescribed HIV Preexposure Prophylaxis (PrEP) medications, offer related testing and counseling services as determined by your healthcare provider.
HIV Test	Age 19-65, offer one time testing with unknown risk for HIV. Periodic repeat testing with continued risk factors.
Latent Tuberculosis (TB) Infection Test	Age 19 and older at high risk, offer one time testing. Periodic repeat testing with continued risk factors.
Low-dose CT Scan for Lung Cancer	Age 50-80 at high risk, test annually until smoke-free for 15 years.
Obesity/Weight Loss Interventions	Age 19 and older with a BMI of 30 or greater: Offer behavioral interventions.
STI Counseling	Age 19 and older at increased risk: Behavioral counseling as determined by your healthcare provider.
Skin Cancer Prevention Counseling	Age 19-24: Counseling to minimize exposure to ultraviolet (UV) radiation for adults with fair skin.
Syphilis Test	Age 19 and older test if at high-risk. Periodic repeat testing with continued risk factors as determined by your healthcare provider.
Tobacco Use Assessment/ Counseling/Cessation Interventions	Age 19 and older: 2 cessation attempts per year including behavioral counseling interventions (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); Food and Drug Administration (FDA)-approved tobacco cessation medications.[5]
IMMUNIZATIONS**	
COVID-19	Age 19 and older: 2 or 3 dose primary series and booster.
Haemophilus Influenza Type B (Hib)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 3 doses depending on indication.
Hepatitis A (HepA)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2, 3 or 4 doses.
Hepatitis B (HepB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 to 4 doses.
Human Papillomavirus (~~9v~~HPV)	Age 19-45: 2 or 3 doses, depending on age at series initiation or healthcare provider recommendation.
Influenza	Age 19 and older: 1 dose annually.
Measles/Mumps/Rubella (MMR)	Age 19 and older: Based on indication (born 1957 or later) or healthcare provider recommendation, 1 or 2 doses.
Meningococcal A, C, W, Y	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 2 doses depending on indication, then booster every 5 years if risk remains.
Meningococcal B (MenB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 or 3 doses depending on indication, then booster every 2-3 years if risk remains.
Monkeypox (Mpox)	Age 19 and older based on individual risk or healthcare provider recommendation, 2 doses.
Pneumococcal (PCV)	Age 19 and older: Based on individual risk and healthcare provider recommendation, 1 or 2 doses.
Respiratory Syncytial Virus (RSV)	Age 50 and older: Based on individual risk and healthcare provider recommendation, 1 dose annually.
Tetanus/Diphtheria/Pertussis (Td/Tdap)	Age 19 and older: 1 dose of Tdap, then Td or Tdap booster every 10 years.
Varicella/Chickenpox (VAR)	Beginning at age 19: 1 or 2 doses (born 1980 or later) based upon past immunization or medical history.
Zoster/Shingles (RZV)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 doses.

[1] Coverage is provided without cost-share for all FDA-approved contraceptive methods. See the Rx Preventive Coverage List at capitalbluecross.com for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If a member's provider recommends a specific FDA-approved method based on medical necessity, the service or item is covered without cost-sharing.
[2] CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy.
[3] Only one endoscopic procedure is covered at a time.
[4] For guaiac-based testing (gFOBT), six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing (FIT), specific manufacturer's instructions are followed.
[5] Refer to the most recent formulary located on the Capital Blue Cross website at capitalbluecross.com.

Schedule for Maternity

SCREENING/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:

- Alcohol Use Screening/Counseling
- Anemia Screening (CBC)
- Anxiety/Depression Screening (prenatal/postpartum)
- Breastfeeding Support/Counseling/Supplies
- Gestational Diabetes Screening (prenatal/postpartum)
- Healthy Weight Gain during Pregnancy
- Hepatitis B Screening (first prenatal visit)
- HIV Screening•
- Low-dose Aspirin Therapy (after 12 weeks gestation with high- risk for preeclampsia)
- Preeclampsia Screening
- Rh Blood Typing
- Rh Antibody Testing for Rh-negative Women
- Rubella Titer
- STI Screening/Testing (Chlamydia/Gonorrhea/Syphilis)
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Urine Bacteria Screening (Asymptomatic)
- Other preventive services may be available as determined by your healthcare provider

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

GENERAL HEALTHCARE

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

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (through 24 months)
- Height/Length/Weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Sudden cardiac arrest/death (risk assessment beginning 11 years of age)
- Weight for Length (through 18 months)
- Anticipatory guidance for age-appropriate issues including:
  - Growth and development, obesity prevention, physical activity and psychosocial/behavioral health
  - Breastfeeding/nutrition/support/counseling/supplies
  - Safety, unintentional injuries, firearms, poisoning, media access
  - Contraceptive methods/counseling (females)
  - Alcohol, tobacco, or drug use assessment/education
  - Oral health risk assessment/dental care/fluoride supplementation (greater than 6 months)[1]
  - Fluoride varnish painting of primary teeth (up to age 5 years)
  - Folic Acid (childbearing age)

	Newborn	9-12 months	1 year	2y years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
Alcohol, Tobacco and Drug Use Assessment (CRAFFT)													✓	✓	✓	✓	✓	✓	✓	✓	✓
Alcohol Use Screening/Counseling																				✓	✓
Anemia Screening			✓	Assess risk at all other well child visits																	
Anxiety/Depression/Suicide Risk Screening										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Autism Spectrum Disorder Screening	At 18 months			✓																	
Chlamydia and Gonorrhea Test	For sexually active females: suggested testing interval is 1-3 years.																				
Developmental Screening		✓	✓	✓	At 9 months, 18 months, and 30 months.																
Domestic/Intimate/Partner Violence Screening and Support	Annually for adolescents of childbearing age, 11 years and older; offer support services as determined by your healthcare provider.																				
Hearing Screening/Risk Assessment	Between 3-5 days through 3 years; repeat at 7 and 9 years.																				
Hearing Test (objective method)	✓					✓	✓	✓		✓		✓	Once between ages 11-14, 15-17 and 18+								
Hepatitis B Test	Beginning at newborn, screening if at high-risk for infection. Periodic repeat testing of children with continued high risk.																				
Hepatitis C Test	One-time testing beginning at age 18 years. Periodic repeat testing with continued high risk.																			✓	✓
High Blood Pressure (HBP)					✓	Beginning at 3 years or younger if at high-risk: At every well-child visit. Ambulatory Blood Pressure Monitoring (ABPM) recommended for confirming HBP.															
HIV Screening/Risk Assessment													✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV Test	Routine one-time testing between 15-18 years old. If indicated by high-risk assessment testing may begin earlier. Periodic repeat testing (at least annually) of all high-risk children.																				
Lead Screening Test/Risk Assessment	Screening Test: 12 to 24 months (at risk) 2; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid Screening/ Risk Assessment				✓		✓		✓		✓				✓	✓	✓	✓	✓	✓		
Lipid Test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal Depression Screening	By 1 month, 2 months, 4 months, and 6 months.																				
Newborn Bilirubin Screening	✓																				
Newborn Blood Screen *(as mandated by the PA Department of Health)*	✓																				
Newborn Critical Congenital Heart Defect Screening	✓																				
Obesity								✓	Beginning at 6 years: At every well-child visit. Offer/refer to intensive counseling and behavioral interventions.												

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
STI Screening/Counseling	Beginning at 11 years (at risk, if sexually active): Offer behavioral counseling.												✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Cancer Prevention Counseling	Beginning at 6 months, counseling to minimize exposure to ultraviolet (UV) radiation for children with fair skin.																				
Syphilis Test	For high-risk children; suggested testing interval is 1-3 years.																				
Tobacco Smoking Screening and Cessation	Beginning at age 18: Two (2) cessation attempts per year including behavioral counseling interventions; (each attempt includes a maximum of 4 counseling visits); FDA approved tobacco cessation medications[3]																			✓	✓
Tuberculin Test	Assess risk at every well child visit, test if recommended by healthcare provider.																				
Vision Risk Assessment	Up to 2 1/2 years								✓		✓		✓		✓	✓		✓	✓	✓	✓
Vision Test (objective method)					✓	✓	✓	✓		✓		✓		✓			✓				
	Optional annual instrument-based testing may be used between 1-5 years of age and between 6-19 years of age in uncooperative children.																				

IMMUNIZATIONS**	
COVID-19	6 months – 18 years; 2 or 3 primary dose series and booster
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years; 5 doses
Haemophilus Influenza Type B (Hib)	2 months, 4 months, 6 months, 12–15 months, and 1–18 years based on individual risk; 3 or 4 doses
Hepatitis A (HepA)	12–23 months; 2 doses
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months; 3 doses
Human Papillomavirus (HPV)	9-18 years: Starting age and doses are based on individual risk and healthcare provider recommendations; 2 or 3 doses
Influenza[4]	6 months–18 years; annual vaccination, 1 or 2 doses
Measles/Mumps/Rubella (MMR)	12–15 months, 4–6 years; 2 doses
Meningococcal	11–12 years, 16 years; 2 months–18 years for those at high-risk; 2 doses
Meningococcal B (MenB)	10–18 years based on individual risk or healthcare provider recommendation; 2 or 3 doses
Monkeypox (Mpox)	Age 18 and older based on individual risk or healthcare provider recommendation, 2 doses
Pneumococcal (PCV)	2 months, 4 months, 6 months, 12–15 months and 2-18 years based on individual risk and healthcare provider recommendation; 4 doses
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years; 4 doses
Respiratory Syncytial Virus (RSV)	Birth, 1–19 months; 1 dose. Children up to 24 months based on individual risk or healthcare provider recommendation; 1 dose annually
Rotavirus (RV)	2 months, 4 months, 6 months; 2 or 3 doses
Tetanus/Reduced Diphtheria/Pertussis (Tdap)	11–12 years; 1 dose
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years; 2 doses

1 Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
2 Encourage all PA Children's Health Insurance Program (CHIP) Members to undergo blood lead level testing before age 2 years. If not previously tested, test between the ages of 3 to 6 years old.
3 Refer to the most recent formulary located on the Capital Blue Cross web site at capitalbluecross.com.
4 Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (greater than 4 weeks apart), both of which are covered.
* Services that need to be performed more frequently than stated due to specific health needs of the member and 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 including special situations and catch-up vaccinations if necessary.

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).

Healthcare benefit programs issued or administered by Capital Blue Cross 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 Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Applicable Group Numbers

00500046 PPO Plan 23

July, 2026