



Lafayette College

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**Rx CARD PLAN
FOR PRESCRIPTION DRUG BENEFITS
BENEFITS BOOKLET**

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



NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201

Toll-free: 800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员 · 请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

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무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

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

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

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Aby porozmawiac z tłumaczem w języku polskim, proszę zadzwonić na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

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

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).

請致電 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 Sprachassistenzen 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 કોલ 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।

Table of Contents

WELCOME.....	1
IMPORTANT NOTICES.....	2
HOW TO CONTACT US.....	3
DEFINITIONS.....	4
HOW TO ACCESS BENEFITS.....	10
SUMMARY OF COST SHARING AND BENEFITS	16
COST SHARING DESCRIPTIONS.....	20
BENEFITS DESCRIPTIONS	22
SCHEDULE OF LIMITATIONS	23
EXCLUSIONS	24
PHARMACEUTICAL UTILIZATION MANAGEMENT PROGRAMS.....	28
MEMBERSHIP STATUS	31
TERMINATION OF COVERAGE.....	37
CONTINUATION OF COVERAGE AFTER TERMINATION	39
CLAIMS REIMBURSEMENT.....	40
APPEAL PROCEDURES	44
GENERAL PROVISIONS	47
ADDITIONAL INFORMATION.....	53

WELCOME

Thank you for choosing *prescription drug 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. **Prescription Drug 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.

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 and prescription drug expenses. You should read this *Benefits Booklet* carefully to determine which *prescription drugs* and services are coverage.
- To receive certain *benefits* and pay the least for your prescriptions drugs and related services, use *in-network pharmacies*.
- 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 and pharmaceutical utilization management. These programs help us make sure you receive the quality of care you need at the best price. Refer to the **Pharmaceutical Utilization Management** section for more details
- *Medical necessity* is based on whether *prescription drugs* and related services are appropriate and are 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 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 *prior authorization* for pharmaceuticals. 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 users 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 Patrick O'Donnell Pavilion WellSpan Health Campus 12 St. Paul Drive Chambersburg, PA 17201 Hampden Marketplace 4500 Marketplace Way Enola, PA 17025 Capital Blue Cross 1221 Hamilton Street Allentown, PA 18102 Apple Hill Medical Center 25 Monument Rd., Suite 220A York, PA 17402

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 pharmacies*, the allowed amount is the lesser of the *in-network pharmacy's* actual charge or the amount agreed to between the pharmacy benefits manager (PBM) and us.
- For *out-of-network pharmacies*, the allowed amount is the lesser of the *out-of-network pharmacy's* actual charge or the in-network pharmacy level.

Ancillary Charge(s): The difference in cost you must pay if you or your *provider* choose a *brand drug* when a generic drug is available. *Ancillary charges* do not apply to the *deductible* or *out-of-pocket maximum*.

Annual Enrollment: Those *medically necessary prescription drugs*, services, *diabetic supplies*, and other supplies covered under this *coverage*.

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.

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.

Benefits: Those *medically necessary prescription drugs*, services, *diabetic supplies*, and other supplies 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.

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

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

Brand Preferred Drug: A medication that has been reviewed and approved by our Pharmacy and Therapeutics committee and found to have a therapeutic advantage or overall value over brand nonpreferred that treat the same condition, factoring in safety, efficacy, and cost.

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

Coinsurance: The percentage of the *allowed amount* you pay for certain *benefits*. You must pay coinsurance directly to the *pharmacy* at the time services are rendered. Coinsurance percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** or in the applicable rider to this *Benefits Booklet*.

Compound Drug: A product prepared by a pharmacist from a prescription drug order that results from the combining, mixing, or altering of two or more ingredients, excluding flavorings, to create a customized drug.

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.

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

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*.

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 for *benefits*. Cost sharing amounts include: *copayments*, *deductibles*, *coinsurance*, and *ancillary charges*.

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

Covered Drugs: Unless specifically excluded, all *prescription drugs*, preventive drugs mandated by law, and any diabetic supplies dispensed per a valid *prescription order* for your *outpatient* use.

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.

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

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

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.

Formulary: A continually updated list of covered *prescription drugs*.

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

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

Home Delivery Dispensing: The dispensing of maintenance *prescription drugs* through the designated *home delivery pharmacy* in quantities up to a 90-day supply per *prescription order*.

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

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.

In-Network Pharmacy: A *pharmacy* or other *prescription drug* provider approved by us, licensed where required and engaged by us or our *PBM* to provide *benefits* to you. The status of a *pharmacy* as an in-network *pharmacy* may change from time to time. It is your responsibility to verify the current status of a *pharmacy*.

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.

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 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 Synchronization: The coordination of *prescription drug* filling or refilling by a *pharmacy* or dispensing *physician* for a *member* taking two or more maintenance medications to improve medication adherence.

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*.

Out-of-Network Pharmacy: A *pharmacy* that is not under contract, directly or indirectly, with us or our *PBM*.

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*.

Over-the-Counter (OTC): A drug defined by the Food and Drug Administration (FDA) as safe and effective for use by the general public without seeking treatment by a health professional and for which a prescription is not legally required.

Pharmacy: A pharmacy or other *prescription drug* provider that is licensed in the state in which it practices or is located, provides covered services, and performs services within the scope of their licensure.

Pharmacy Benefit Manager (PBM): The pharmacy benefit manager under contract with us to help in the administration of the drug *benefits* under the *group contract*.

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

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),

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

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

Preventive Drug Coverage: Certain categories of *over-the-counter* and *prescription drugs* for which coverage is mandated by law as included in preventive care services coverage based on recommendations from the U.S. Preventive Services Task Force as well as the Institute of Medicine.

Prior Authorization: A *prescription drug* authorization (or approval) from us or our designee that results from a process used to decide *medical necessity* based on clinical practice guidelines, with a requirement that specific criteria are met.

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

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

Retail Pharmacy: Any *pharmacy* licensed to sell and dispense *prescription drugs* excluding a *home delivery pharmacy* and excluding a *pharmacy* that dispenses *prescription drugs* solely via the internet.

Retiree: A former employee of the *contract holder* who meets the *contract holder's* definition of a retired employee and to whom the *contract holder* offers *coverage* under the *group contract*, if any. The *contract holder* must designate and 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 *approved 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.

Specialty Medication Preferred Network: Specialty pharmacies contracted with and chosen by us to dispense *specialty prescription drugs*.

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

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

Step Therapy: A course of treatment in which certain designated drugs or treatment protocols must be either contraindicated, or used and found to be ineffective, prior to approval of coverage of other designated drugs or treatment protocols. The term does not include requests for coverage of nonformulary drugs.

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*.

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 obtain prescription drugs and related services**. *Pharmacists* use the *ID card* information to submit *claims* for payment.

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 Prescription Drugs

The Formulary

Your prescription plan uses our Advantage formulary, which provides you access to quality, affordable medications and provides *provider* with a reference list of preferred medications for cost-effective prescribing. The *formulary* is updated by our Pharmacy and Therapeutics committee quarterly or when new generic or brand name medications become available, or as discontinued drugs are removed from the marketplace.

The *formulary* lists medications by therapeutic class. Each drug falls into one of the following categories: *generic preferred*, *generic nonpreferred*, *brand preferred*, or *brand nonpreferred*. Under this *formulary* system, you are encouraged to use *generic or brand preferred drugs* that typically carry a lower copayment/coinsurance than nonpreferred brand drugs. You will not pay more for a drug if the cost of the drug is less than your *cost sharing amount*.

You can review the *formulary* at CapitalBlueCross.com or request a current copy by calling Member Services. You will find your number on the back of your *ID card*.

Obtaining Benefits for Covered Drugs and Related Services

Depending on your *coverage*, the level of payment for *benefits* is affected by whether you choose an *in-network pharmacy*.

Retail Pharmacy. You can choose any *retail pharmacy* for your *prescription drugs*, although your costs will usually be less when you get your *prescription drugs* from an *in-network retail pharmacy*. You may visit an *out-of-network retail pharmacy*, but it generally will cost you more.

Home Delivery Pharmacy. You must use the *home delivery pharmacy* designated by us to receive *benefits* under this *coverage*.

Specialty Pharmacy. If you use select *specialty prescription drugs* as noted on the *formulary* must use the *specialty medication preferred network* designated by us to receive *benefits* under this *coverage*.

Prescription Drugs and Related Services Provided by In-Network Pharmacies

An *in-network pharmacy* is a *pharmacy* or other *prescription drug provider* that is approved by us, where required, is licensed in the Commonwealth of Pennsylvania (or such other jurisdiction approved by us), and has entered into a *provider agreement* with or is otherwise engaged by us or our *PBM* to provide *benefits* to you.

How To Access Benefits

In-network pharmacies agree to accept our payment, along with any applicable *cost sharing amounts* that you are required to pay, as payment in full. As a result, you can maximize your *coverage* and minimize your out-of-pocket expenses by using an *in-network pharmacy*.

Also, *in-network pharmacies* will not transfer your prescriptions without your request or permission.

Other than *cost sharing amounts*, *in-network pharmacies* may not seek payment from you for *prescription drugs* and/or services that qualify as *benefits*. However, an *in-network pharmacy* may ask you to pay for noncovered *prescription drugs* and services, excluded *prescription drugs* and services, or services over quantity/day supply maximums. Before providing the noncovered *prescription drugs* and/or services, the *in-network pharmacy* must tell you that you may be liable to pay for these *prescription drugs* and/or services, and you must agree to accept this liability.

The network status of a *pharmacy* may change from time to time. It is your responsibility to check the current status of a *pharmacy*. To find an *in-network pharmacy*, you can go to CapitalBlueCross.com or call Member Services. You will find the number on the back of your *ID card*.

Prescription Drugs and Related Services Provided by Out-of-Network Pharmacies

Prescription drugs and/or services received from an *out-of-network pharmacy* may cost more or may not be covered. If such *prescription drugs* and/or services are covered, *benefits* will be paid based on the *allowed amount*.

You may need to pay the difference between the *out-of-network pharmacy's* charge for a *prescription drug* and/or service and the *allowed amount* for that *prescription drug* and/or service. This difference is called the balance billing charge. There can be a significant difference between what we pay for a *prescription drug* and/or service and what the *pharmacy* charged. See the **Cost Sharing Descriptions** section for more information on balance billing charges.

Retail Dispensing Benefits

To receive *retail dispensing benefits*, you should present your *ID card* to the *in-network pharmacy*. The *in-network pharmacy* will supply *covered drugs* up to the applicable day supply limit and will not charge you or collect from you any amount, except for any applicable *cost sharing amounts*. To be paid for *covered drugs* dispensed by an *out-of-network pharmacy* or purchased without the *ID card*, you must submit a claim for payment using the *prescription drug* claim form that you can access at CapitalBlueCross.com.

Refills may be dispensed subject to federal and state law limitations, and only in accordance with the number of refills listed on the original *prescription order*. Refills may not be dispensed more than one year after the date of the original *prescription order*. You must use 75% of the previous supply dispensed through *retail dispensing* in accordance with the associated *prescription order* before a covered drug can be refilled. Extended release opioid medications will only be dispensed if you have used 83% of the previous supply. Prescription eye drops will be dispensed only if you have used 70% of the previous supply.

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

MedsYourWay Retail Program

Your prescription plan includes the MedsYourWay Retail Program, which tries to find the lowest out-of-pocket price available to you for many of the most common drugs. The program will search for the lowest price at the point of sale (i.e., retail pharmacies) from multiple different discount cards and your health plan benefit. Simply present your *ID card* at an *in-network retail pharmacy* and MedsYourWay will price shop for you to maximize your savings opportunities on most drugs. Unlike other separate drug discount cards and platforms, the MedsYourWay Retail Program ensures that all amounts that you pay for *covered drugs* will apply towards your annual *deductible* and maximum *out-of-pocket* limit, as long as you present your *ID card* to the *pharmacy* to process your prescription drug claims.

Eligibility for the MedsYourWay Retail Program, as well as the Program's terms including the in-scope prescription drugs, participating retail pharmacy locations, and any state exclusions, are subject to change with or without notice.

Home Delivery Dispensing Benefits

You can fill *covered drugs*, subject to any applicable *cost sharing amount*, through the designated *home delivery pharmacy* in quantities up to a 90-day supply. Through the Extended Supply program, 90-day supply may also be dispensed at any in-network retail pharmacy.

To order by mail, send the following items to the designated *home delivery pharmacy*:

- A completed home delivery registration and prescription order form
- The method of payment for applicable *copayment* and/or *coinsurance*.
- The *prescription order*.

You can find the home delivery order forms by:

- Going to CapitalBlueCross.com.
- Calling Member Services at the phone number listed on your *ID card*.
- Using the subsequent order forms included with the delivery of the covered drug.

Refills are subject to federal and state law limits, and the number of refills listed on the original *prescription order*. Refills may not be dispensed more than one year after the date of the original *prescription order*. You must use 60% of your previous supply before a prescription can be refilled. (Extended release opioid medications will only be dispensed if you have used 83% of the previous supply.) Allow up to 14 days for delivery and have at least two weeks of medication on hand when ordering any refills.

Certain *prescription drugs* are not available for *home delivery dispensing* due to safety and quality concerns. These *prescription drugs* are available through *retail dispensing* or specialty pharmacy dispensing only. If you have questions on the availability of a drug through home delivery, call the telephone number on the back of your *ID card*.

Specialty Prescription Drug Benefits

Specialty prescription drugs are specialty oral and other self-administered *prescription drugs* typically used in the treatment of complex and potentially life-threatening illnesses. These medications usually require special handling and storage.

If you need select *specialty prescription drugs*, you must use our designated *specialty medication preferred network* to receive *benefits* under this coverage. Select *specialty prescription drugs* are

available exclusively through the *specialty medication preferred network*. Specialty medications are limited to a 30-day supply.

Certain *specialty prescription drugs* are limited distribution drugs (LDD). LDDs are specialty medications that the manufacturer limits distribution to only a few specialty pharmacies. Specialty LDDs that are not available through the *specialty medication preferred network* will be available through the pharmacy identified by the manufacturer.

You must use 75% of your previous supply before a prescription can be refilled. (Extended release opioid medications will only be dispensed if you have used 83% of the previous supply.)

To see the most current list of *specialty prescription drugs*, view your *formulary* at CapitalBlueCross.com, or request a current copy of the *formulary* by calling Member Services. You will find the number on the back of your *ID card*.

For more information or to begin service, call 833.721.1626 , TTY: **800.716.3231** or have your provider fax the prescription to 888.602.1028 .

FlexAccess Program

Your prescription plan includes the FlexAccess Program, which helps maximize the value of pharmaceutical manufacturer financial assistance programs and more accurately tracks your cost sharing accumulations under the *plan*.

When you obtain a covered *prescription drug* that is in-scope for the FlexAccess Program, you will be automatically enrolled and receive any available pharmaceutical manufacturer financial assistance for which you are eligible for that *prescription drug*. While the *cost sharing amounts* under this plan still apply to you, the program may effectively reduce or eliminate your actual out-of-pocket expense for certain covered *prescription drugs* for as long as the drugs are covered under the program. Only amounts actually paid by you, and not the amount of any pharmaceutical manufacturer financial assistance, will accumulate toward your *deductible* or *out-of-pocket maximum*, as applicable.

While you are taking part in this program, you will receive the benefit of the financial assistance at the point of sale, as a reduction to the amount of the purchase price that you owe for the *prescription drug*.

Eligibility for the program and the *prescription drugs* in-scope are subject to change with or without advance notice.

Requests for Exceptions to the Formulary (Nonformulary Exception)

Standard Nonformulary Exception

If you are prescribed a drug that is not on the formulary (or is nonpreferred), you have two options:

You may ask us for a list of similar drugs that are on the *formulary* and ask your provider to prescribe a drug on the list if appropriate.

You, your authorized representative, or your *provider* may also ask us to make an exception to cover a drug that is not on the *formulary*. This request is known as a nonformulary exception request. If we grant a request to cover a nonformulary drug, you may not request a higher level of *coverage*. A request for a nonformulary exception should be made by calling the Member Services number listed on the back of your *ID card* or writing our Pharmacy Benefit Manager (PBM) at:

Pharmacy Services
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

A request for an exception may be approved if alternative drugs or a lower tier drug included on the *formulary* would not be as effective in treating your condition or would cause you to have adverse medical effects.

A request for a nonformulary drug exception should include a statement by your *provider* supporting the request. We will make a decision granting or denying the request no later than 72 hours from receipt of the request if there is sufficient information to process the request. If more information is needed to process the request, the decision will be made no later than 72 hours from when sufficient information is received.

If we grant the exception request, the nonformulary drug will be covered for the duration of the prescription, including any refills.

Expedited Nonformulary Exception

You or your provider may request an expedited nonformulary exception determination if:

- (1) Your life, health or ability to regain maximum function could be seriously harmed by waiting up to 72 hours for a decision or
- (2) You are undergoing a current course of treatment using a nonformulary drug.

In such cases, we will make a decision no later than 24 hours after receiving the expedited exception request if there is sufficient information to process the request. If more information is needed, the decision will be made no later than 24 hours from when sufficient information is received. A request for either a standard or an expedited exception determination should be made by calling the Member Services number on the back of your ID card.

Appealing a Standard or Expedited Nonformulary Exception Denial

If we deny your nonformulary exception request, you, or your authorized representative may appeal the denial (i.e., request an internal appeal) by calling us at the following number:

855.500.CARE (2273)

Or writing to us at:

Appeals & Grievances Resolution Unit
Capital Blue Cross
PO Box 779518
Harrisburg, PA 17177-9518

In reviewing the internal appeal request, *Capital* will use health care professionals with proper medical training and experience for the appeal matter who were not involved in, or the subordinates of those who were involved in, the nonformulary drug exception request denial.

For appeals of a standard nonformulary drug exception request denial, we will make a decision no later than 30 days from the receipt of your appeal request.

You or your authorized representative may request an expedited nonformulary exception appeal if (1) your life, health, or ability to regain maximum function could be seriously harmed by waiting up to 30 days for an appeal decision, or (2) you are undergoing a current course of treatment using a non-formulary drug. For an expedited appeal of a nonformulary drug exception request denial, we will make a decision no later than 72 hours after receiving the appeal request.

SUMMARY OF COST SHARING AND BENEFITS

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

The *benefits* listed in this section are covered in accordance with our *pharmaceutical utilization 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** and **Schedule of Exclusions** sections for a specific description of the *benefits* and *benefit* limitations provided under this *coverage*.

SUMMARY OF COST SHARING – PRESCRIPTION DRUG BENEFITS			
You are responsible for paying your deductible and any copayments and coinsurance reflected in this chart.			
	Amounts You Are Responsible For:		
	Retail	Home Delivery	Specialty Pharmacy
Copayments			
• Generic Preferred Drug	\$10 copayment after deductible	\$20 copayment after deductible	\$70 copayment after deductible
• Generic Nonpreferred Drug	\$10 copayment after deductible	\$20 copayment after deductible	\$70 copayment after deductible
• Brand Preferred Drug	\$35 copayment after deductible	\$70 copayment after deductible	\$70 copayment after deductible
• Brand Nonpreferred Drug	\$55 copayment after deductible	\$110 copayment after deductible	\$70 copayment after deductible
Copayments for Contraceptives (Self-Administered)			
• Generic Preferred Drug*	Not Applicable	Not Applicable	Not Covered
• Generic Nonpreferred Drug*	Not Applicable	Not Applicable	Not Covered
• Brand Preferred Drug	\$35 copayment after deductible	\$70 copayment after deductible	Not Covered
• Brand Nonpreferred Drug** *For contraceptive therapeutic categories with no generic option, an available FDA-approved brand drug as determined by Capital may be purchased at no cost share to you. ** Coverage of a brand nonpreferred contraceptive at \$0 cost share can be requested by you through the prior authorization process as described in the Pharmaceutical Utilization Management section.	\$55 copayment after deductible	\$110 copayment after deductible	Not Covered

Summary of Cost Sharing and Benefits

SUMMARY OF COST SHARING – PRESCRIPTION DRUG BENEFITS			
You are responsible for paying your deductible and any copayments and coinsurance reflected in this chart.			
	Amounts You Are Responsible For:		
	Retail	Home Delivery	Specialty Pharmacy
Deductible† – Applies to Brand Preferred and Brand Nonpreferred Drug only. Copayments and coinsurance do not apply to the deductible.			
In-Network Providers	\$200 per member \$600 per family		
Out-of-Network Providers	Not Applicable		
Coinsurance			
• Generic Preferred Drug	Not Applicable	Not Applicable	Not Applicable
• Generic Nonpreferred Drug	Not Applicable	Not Applicable	Not Applicable
• Brand Preferred Drug	Not Applicable	Not Applicable	Not Applicable
• Brand Nonpreferred Drug	Not Applicable	Not Applicable	Not Applicable
• Preventive Drug Coverage (other than Prescription Contraceptives)	No Cost Share	No Cost Share	No Cost Share
Out-of-Pocket Maximum†			
In-Network Providers	\$4,000 per member \$8,000 per family This in-network out-of-pocket maximum is combined with the in-network out-of-pocket maximum for medical benefits. This combined out-of-pocket maximum can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, or a combination of the two.		
Out-of-Network Providers	Not Applicable The following expenses do not apply to the out-of-pocket maximum: • Deductible (out-of-network provider only); • Amounts paid by you to an out-of-network pharmacy that are more than the amount we paid to you for covered drugs; • Amounts you paid for a brand drug that are more than our allowed amount (ancillary charge) when a generic drug is available and • Charges exceeding the allowed amount.		
†We do not apply manufacturer cost share assistance program payments (e.g., manufacturer discount plans or coupons) to your deductible or out-of-pocket maximum.			
Benefit Period Maximum	\$2,500 for fertility drugs		

Summary of Cost Sharing and Benefits

SUMMARY OF RESTRICTIONS – PRESCRIPTION DRUG BENEFITS			
	Retail	Home Delivery	Specialty Pharmacy
Days' Supply	Up to 31 days	Up to 90 days	Up to 30 days
Pharmacy Network	Broad Plus		
Formulary	Advantage		
Ample Days' Supply Limit	Prescription drug refills will be dispensed only if you have used 60% of the previous supply dispensed through the designated Home Delivery Pharmacy or 75% of the previous supply dispensed through a Retail Pharmacy or Specialty Pharmacy. (Extended release opioid medications will only be dispensed if you have used 83% of the previous supply). Prescription eye drops may be dispensed only if you have used 70% of the previous supply.		
Drug Quantity Management (Quantity Level Limits)	Prescription drugs that have quantity level limits are noted in the formulary. The quantity level limits set the maximum allowable quantity of a prescription drug that may be dispensed per prescription order, per date of service, or per month. If your prescription is written for more than an allowed quantity, the pharmacy will only fill up to the allowed amount		
Prior Authorization	To be eligible as a covered drug, select prescription drugs require prior authorization before the prescription drug is dispensed by the pharmacy		
Step Therapy	This program encourages the use of covered drugs that should be tried first before coverage is available for other therapies		
Specialty Medication Preferred Network	For most Specialty Medications, coverage is available only when dispensed by a specialty medication vendor contracted with us.		
Extended Supply Network	The dispensing of maintenance drugs for up to a 90-day supply available through any in-network retail pharmacy or home delivery pharmacy. Ample days' supply limit of 60% applies .		
Mandatory Generic Substitution Policy	If a <i>generic drug</i> is available and you request the brand-name drug, you must pay the cost difference between the brand-name drug and its generic cost (<i>ancillary charge</i>). You also must pay the applicable brand <i>copayment</i> or <i>coinsurance</i> , up to the original cost of the brand-name drug, even if your prescriber indicates "dispensed as written" or "DAW" in place of an approved <i>generic drug</i> equivalent.		

Summary of Cost Sharing and Benefits

SUMMARY OF BENEFITS – PRESCRIPTION DRUGS

This list is a summary of the most frequently used prescription drug therapeutic classes. It is not a complete list of prescription drugs. You should refer to the formulary on CapitalBlueCross.com for the most up to date prescription drug information.

Prescription Drug Category	Retail (Up to a 31-day supply)	Home Delivery (Up to a 90-day supply)	Specialty Pharmacy (Up to a 30-day supply)
Acne Products	Covered	Covered	Not Covered
Anti-flu therapy	Covered	Not Covered	Not Covered
Compound Drugs (not including OTC)*	Covered	Not Covered	Not Covered
Contraceptives (Self-Administered)	Covered	Covered	Not Covered
Diabetic Supplies	Covered	Covered	Not Covered
Fertility (except as mandated by law)	Covered	Covered	Not Covered
Nicotine Cessation Drugs **	Covered	Covered	Not Covered
Over-the-Counter (OTC)* Products (except as mandated by law)	Not Covered	Not Covered	Not Covered
Sexual Dysfunction Drugs	Covered	Covered	Not Covered
Specialty Drugs (Self-Administered)	Not Covered	Not Covered	Covered
Weight Loss Drugs	Not Covered	Not Covered	Not Covered
Vitamins	Covered	Covered	Not Covered

*Over-the-counter (OTC) drugs require a prescription and must be dispensed by a pharmacy for coverage.

**We cover FDA approved nicotine cessation medications (both prescription and over-the-counter) at no cost share for a 90-day treatment (up to two attempts per benefit period). The medication must be prescribed by a healthcare provider and does not require prior authorization.

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 *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:

- *Ancillary charges*, as described in the **Mandatory Generic Substitution** section.
- Balance billing charges, you owe to an *out-of-network pharmacy*.
- Services for noncovered *benefits*, regardless of the *pharmacy's* participation status.

Copayment

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

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*.

For each *deductible* amount that may apply to this *coverage*, two *deductible* amounts may apply: an individual *deductible* and a family *deductible*. Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. In calculating the family *deductible*, we will apply the amounts satisfied by each *member* toward their individual *deductible*. However, the amounts paid by each *member* towards the family *deductible* are limited to 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*.

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* that you must pay for a *benefit*.

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

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*.

The out-of-pocket 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 *out-of-pocket maximum(s)* that apply to your coverage.

Balance Billing Charges

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

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

- For *in-network pharmacies*, the *pharmacy* has agreed to accept the amount paid by us (minus any *cost sharing amount* you owe) as payment in full. *In-network pharmacies* will not balance bill you for covered services.
- For *out-of-network pharmacies*, the *allowed amount* for a *benefit* typically determines the maximum amount we will pay for *benefits*. Since the *out-of-network pharmacy* does not have a contract to provide *prescription drugs* or services to *our members*, the *pharmacy* has not agreed to accept our payment, minus any *cost sharing amount* due from you, as payment in full. The *allowed amount* in these situations can be less than the *pharmacy's charge*. Therefore, you will also need to pay the difference between the *pharmacy's charge* and the *allowed amount*, in addition to any applicable *cost sharing amount*. All payment for *prescription drugs* and services provided by an *out-of-network pharmacy* will be made to the *subscriber*.

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 *pharmacy* according to the terms of this *Benefits Booklet*, c) they are prior authorized (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 *prescription drug*, a therapeutic class of *prescription drugs*, and/or a service 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 *pharmacies* for covered *benefits*, and if any *benefit limitations/maximums* apply to the *benefit*.

Benefits for prescription drugs include *prescription drugs* dispensed for your *outpatient* use. You may purchase *prescription drugs* at *retail pharmacies*, through the designated *home delivery pharmacy*, or through the designated specialty pharmacy.

Certain *prescription drugs* require *prior authorization* or step therapy or are limited to specific quantities by us or our designee.

SCHEDULE OF LIMITATIONS

The *benefits* provided under your *prescription drug* coverage have the following limitations:

1. A *pharmacy* need not dispense a *prescription order* that, in its professional judgment, should not be filled for any reason.
2. You may purchase a *brand drug*, even if an approved *generic drug* equivalent could be used to treat your condition. If, however, you purchases a *brand drug* and such approved *generic drug* equivalent is available, you are responsible for paying the applicable *brand drug coinsurance* and/or *copayment* in addition to the difference in cost between the *brand drug* and the approved *generic drug* equivalent, (i.e. ancillary charge) even if the *prescriber* requests that the *brand drug* be dispensed.
3. Refills may be dispensed subject to federal and state law limitations and only in accordance with the number of refills listed on the original *prescription order*. Refills may not be dispensed more than one year after the date of the original *prescription order*.
4. When a *prescription order* is written for a *prescription drug* that has previously been dispensed to you or a *prescription order* is presented for a refill, the *prescription drug* will be dispensed only at such time as you have used 60% of the previous supply dispensed through the designated *home delivery pharmacy* or 75% of the previous supply dispensed through a *retail pharmacy* or specialty pharmacy in accordance with the associated *prescription order*. Extended release opioid medications will only be dispensed if you have used 83% of the previous supply See **Summary of Restrictions Applicable to Prescriptions Drug Benefits** section for example.
5. Certain *prescription drugs* are not available for *home delivery dispensing* due to safety or quality concerns. These *prescription drugs* are available by *retail dispensing* or *specialty pharmacy* dispensing only.
6. All *prescription drugs* are subject to availability at the *retail, specialty, or home delivery pharmacy*.
7. Immunization agents for Preventive Drug Coverage are available at in-network pharmacies licensed to administer immunizations.
8. Select *specialty prescription drugs* will be subject to dispensing only through a designated *specialty pharmacy* unless otherwise approved by us.
9. *Prescription drugs* classified by the federal government as narcotics may be subject to dispensing or dosage limits based on standards of good pharmaceutical practice or state or federal regulations.
10. We reserve the right to decide the reasonable supply of any *prescription drug* based on standards of good pharmaceutical practice.
11. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are subject to quantity limits. *Benefits* for these *prescription drugs* shall be available based on the quantity which we will determine, in our sole discretion, is a reasonable per prescription or per day supply for *retail dispensing, specialty pharmacy dispensing, or home delivery dispensing*.
12. Certain *prescription drugs* require *prior authorization* for coverage prior to the delivery of covered drugs.
13. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are subject to step therapy.
14. *Prescription drugs* utilized to promote fertility are limited to a *benefit period maximum* of \$2,500 per member per *benefit period*.

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, *prescription drugs*, or charges:

- | | |
|---------------------------------|---|
| Clinical Trials | <ul style="list-style-type: none"> • Services or supplies that we consider to be <i>investigational</i>, except <i>routine costs associated with approved clinical trials</i>.
 <i>Routine costs for clinical trials</i> do not include any of the following and are therefore excluded from <i>coverage</i>: <ul style="list-style-type: none"> ○ The investigational drug, biological product, device, medical treatment, or procedure itself, unless otherwise covered under an agreement between a <i>provider</i> and <i>Capital</i> (or other Blue plan) ○ Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient ○ Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis ○ Services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial ○ Your travel expenses |
| Court Ordered Services | <ul style="list-style-type: none"> • Court ordered services when not <i>medically necessary</i> or not a covered <i>benefit</i> |
| Eligibility | <ul style="list-style-type: none"> • Services incurred prior to your <i>effective date of coverage</i> • Services incurred after your <i>coverage</i> termination date except as provided for in this <i>Benefits Booklet</i> • Services from <i>providers</i> that are excluded or debarred from government plans • Services not provided directly to the <i>member</i> |
| Experimental or Investigational | <ul style="list-style-type: none"> • Services or supplies we consider to be <i>investigational</i>, except where otherwise required by law |
| Legal Obligation | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Services not <i>medically necessary</i> as determined by <u>our</u> Medical Director(s) or his/her designee(s) |
| Medicare | <ul style="list-style-type: none"> • Items or services paid for by <i>Medicare</i> when <i>Medicare</i> is primary, consistent with the Medicare Secondary Payer Laws, for any <i>member</i> who is enrolled in Medicare. This exclusion does not apply to the extent the <i>contract holder</i> is required by law to offer the <i>member</i> the <i>benefits</i> of this <i>coverage</i> as primary to <i>Medicare</i>. |

Schedule of Exclusions

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
Motor Vehicle Accident	• Cost of <i>benefits</i> resulting from accidental bodily injury due to a motor vehicle accident, to the extent such <i>benefits</i> are payable under any medical expense payment provision (by whatever terminology used, including such <i>benefits</i> mandated by law) of any motor vehicle insurance policy
Travel	• Travel expenses incurred together with <i>benefits</i> unless specifically identified as a covered service elsewhere in this <i>Benefits Booklet</i>
War	• Any illness or injury suffered after your <i>effective date of coverage</i>, 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.
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if <i>benefits</i> 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 you make a claim for the <i>benefits</i> or compensation under the applicable workers' compensation policy or coverage, or the applicable law.
Prescription Drugs (Drug Program)	• Drugs that we determine do not legally require a prescription unless payment is required by law • <i>Prescription drugs</i> that have an <i>over-the-counter</i> equivalent or <i>over-the-counter</i> alternative, except as mandated by law

Schedule of Exclusions

- Devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for diabetic supplies
- The administration or injection of covered drugs
- *Prescription drugs* received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, residential treatment facility, or similar institution
- All formulations of allergy immunotherapy (including oral), serums, desensitization serums, venom
- *Cost sharing amounts*, differences between *brand drug* and *generic drug* prices (i.e. *ancillary charges*), and balances paid or due to *out-of-network pharmacies* that you must pay under this coverage
- *Prescription drugs* that require *prior authorization* if *prior authorization* is not obtained before dispensing the *prescription drugs*
- *Prescription drugs* that require step therapy if *prior authorization* is not obtained before dispensing the *prescription drugs*
- Quantities that exceed the limits/levels we established, unless *prior authorization* is obtained before the *prescription drug* is dispensed
- Durable medical equipment, except glucose monitors
- Medical foods, blenderized baby food, regular shelf food, or special infant formula, except as required by law
- Immunization agents, except immunization agents for *preventive coverage*, biological sera, blood, blood products
- Requests for reimbursement of *covered drugs* submitted after the allowed time frame for reimbursement except for requests for reimbursements from state and federal agencies
- All *prescription drugs* and *over-the-counter* drugs dispensed:
 - during travel by a *physician* employed by a hotel, cruise line, spa, or similar facility
 - in a *physician's* office or by a *facility provider*
- *Prescription drugs* and *over-the-counter* drugs used:
 - Primarily to enhance physical or athletic performance or appearance
 - for weight loss purposes
 - to promote hair growth
 - for cosmetic purposes
- Injectable medications that cannot be self-administered except immunization agents for *preventive coverage*
- Coverage through coordination of *benefits*
- Requests received through *home delivery dispensing* and submitted for reimbursement under *retail dispensing benefits*
- Requests received through a *retail pharmacy* for *retail dispensing* and submitted for reimbursement under *home delivery dispensing benefits*
- Requests received for select *specialty drugs* that are received through a *retail* or *home delivery pharmacy* and submitted for reimbursement under *specialty drug* dispensing benefits

Schedule of Exclusions

- Replacement of lost, stolen or damaged *prescription drugs*, unless otherwise approved by us
- Prescription drugs used for immunizations needed for travel or employment except as required by law
- Drugs received through an out-of-network home delivery or specialty pharmacy
- *Prescription drugs* used in connection with noncovered medical services
- Any other *prescription drugs* and *over-the-counter* drugs, service or treatment, except as provided in this *Benefits Booklet*.

PHARMACEUTICAL UTILIZATION MANAGEMENT PROGRAMS

Pharmaceutical Utilization Management Programs are designed to safeguard you from potentially harmful drug interactions and side effects. They promote clinically appropriate therapy, *prescription drug* utilization and compliance with recommended drug quantity, dosage and intended use of product.

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

Programs include, but are not limited to the following:

- Drug Utilization Review
- *Prior Authorization*
- Step Therapy
- Drug Quantity Management (Quantity Level Limits)

Our standard products include the full array of Pharmaceutical Utilization Management Programs. Under specific circumstances, groups may choose not to include some or all of the Pharmaceutical Utilization Management Programs described here. Therefore, it is important for you to determine program eligibility with the *contract holder* before assuming that all of these programs are available or apply to you.

Drug Utilization Review (DUR)

Drug utilization review (DUR) evaluates each *prescription drug* dispensed to you against your prescription profile. This profile reflects all *prescription drugs* obtained from in-network *retail pharmacies*, in-network *specialty pharmacies*, and in-network *home delivery pharmacies* while covered by us. Concurrent DUR alerts the *pharmacist* to clinical and plan-specific criteria/edits that call for consideration prior to dispensing. Retrospective DUR alerts the *provider* to potential issues that may require further assessment.

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

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

Investigational Treatment Review

This *coverage* does not include *prescription drugs* and/or services that we or our designee find to be *investigational* as defined in the **Definitions** section.

However, we recognize that situations occur when you choose to pursue *investigational* treatment at your own expense. If you receive a *prescription drug* and/or service which we consider to be

Pharmaceutical Utilization Management Programs

investigational, you are solely responsible for payment of this *prescription drug* and/or service; and the noncovered amount will not be applied to the annual *out-of-pocket maximum* or *deductible*, if applicable.

You, a *provider*, or a *pharmacy* may contact us to find out if we consider a *prescription drug* or service to be *investigational*.

Prior Authorization

To promote appropriate use, select *prescription drugs* require *prior authorization* before the *prescription drug* is dispensed by the *pharmacy* to be eligible as a *covered drug*. These *prescription drugs* are identified in the *formulary*. A copy of the *formulary* can be requested by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card.

Certain *covered drugs*, which are dispensed pursuant to a prescription order for your *outpatient* use, are subject to other limits and/or *prior authorization* requirements, as determined by us in our sole discretion from time to time and as thereafter communicated to you. For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your *ID card*.

You may start a *prior authorization* request by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card. *In-network providers* may help you in obtaining the required *prior authorizations*. However, you are ultimately responsible for ensuring the required *prior authorization* is obtained.

A *prior authorization* decision is generally issued within two days of receiving all necessary information for nonurgent requests.

Step Therapy

Certain covered drugs that are dispensed pursuant to a *prescription order* for your *outpatient* use are subject to other limits and/or Step Therapy requirements, as determined by us in our sole discretion from time to time and as thereafter communicated to you.

Step Therapy uses clinical practice guidelines to encourage the use of the most cost effective and safest drug as a first-line therapy prior to progressing to costlier second-line therapy, if necessary. Drugs that are identified as second line or higher are automatically authorized at the point-of-sale if the prerequisite steps have been met. Drugs subject to Step Therapy are identified in the formulary.

For information as to which covered drugs are subject to any limits and/or Step Therapy, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your *ID card*.

Drug Quantity Management (Quantity Level Limits)

To facilitate proper utilization and encourage the use of therapeutically indicated drug regimens, some *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are limited to specific quantities on a per prescription or per day supply basis. The quantity level limit for each drug is supported by drug studies, U.S. Food and Drug Administration and manufacturer guidelines, medical literature, safety, and accepted medical practice. Quantity level limits are applied to medications when the majority of clinically appropriate utilization will be addressed within the quantity allowed.

Pharmaceutical Utilization Management Programs

Benefits for such *covered drugs* shall be available based on the quantity that we find, in our sole discretion, is a reasonable supply for up to 30 days through *retail dispensing* and *specialty pharmacy dispensing* or up to 90 days through *home delivery dispensing*; or for each *prescription order*.

These *prescription drugs* are identified in the *formulary*. A copy of the *formulary* can be requested by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card.

For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your ID card.

Mandatory Generic Substitution Program

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

When you request a *prescription order* be dispensed with a *brand drug*, that has an approved *generic drug* equivalent, you are responsible for the applicable *brand drug*, *coinsurance* and/or *copayment* and the difference in cost between such *brand drug*, and the *generic drug* equivalent, even if the *prescriber* requires such *brand drug* to be dispensed in place of such *generic drug* equivalent.

Alternative Treatment Plans

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

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

MEMBERSHIP STATUS

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 time frame.

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.**

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 partner is 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:

- 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 *members* "enroll" with us, they 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 *Capital*, through the *contract holder*, an application for *coverage*, which is available from the *contract holder*. Each *member* must also enroll within certain time periods after becoming eligible. These requirements are described in the *group policy*.

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should ask the *contract holder* for the specific time frames 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 time frames 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 time frames. Newly eligible *subscribers* should ask the *contract holder* for the time frames 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 time frames to add the newborn child as a *dependent*. *Subscribers* should consult with the *contract holder* to determine the time frames 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 time frame 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 time frames after the newly eligible *dependent* becomes eligible for *coverage* under the *group contract*. *Subscribers* should consult with the *contract holder* to determine the time frames 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 time frames 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.

Membership Status

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 *Capital's* adverse benefit determination appeal procedures.

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

- *Subscriber* – *Coverage* ends on the date in which a *subscriber* is no longer employed by, or a member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for 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.
- *Overage Dependent* – *Coverage* of overage *dependent* ends on the date in which the child is no longer eligible as an overage *dependent* as described in the **Membership Status** section of this *Benefits Booklet*. The *subscriber*, through the *contract holder*, must notify *Capital* of a change in eligibility status regarding an overage *dependent*. If a notice is not provided, *coverage* ends on the date the overage *dependent* reaches age 30.

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.

Termination of Coverage

- 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.

Coverage for Medicare-Eligible Members

If a *member* is no longer eligible for this *coverage*, is age 65 or older, and is enrolled in *Medicare* Parts A and B; the *member* can enroll in a *Medicare* Supplemental, a Medicare Prescription Drug Plan, or a *Medicare* Advantage product offered by or through arrangements with the Capital 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.

CLAIMS REIMBURSEMENT

Claims and How They Work

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

In-Network Pharmacies

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

Out-of-Network Pharmacies

If you visit an *out-of-network pharmacy*, you will have to pay for the *prescription drug* and/or service at the time the *prescription drug* is dispensed or at the time the service is provided. *Out-of-network pharmacies* do not file claims on your behalf. Therefore, you need to submit your claim to Pharmacy Services at the address list below for reimbursement.

Allowed Amount

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

Filing A Claim

When you submit a prescription to a *retail*, *home delivery*, or *specialty pharmacy*, the prescription is not considered to be a claim. You should call the telephone number on your *ID card* if there are any concerns about fulfillment of the prescription or any of the following occur:

- The pharmacy tells you that you are not eligible for *coverage*.
- *Coverage* for the prescription was denied in whole or in part.
- You feel the wrong cost sharing amount was paid for the prescription.
- You were required to pay other amounts you feel you do not have to pay.
- You have another dispute or discrepancy about the *prescription drug coverage*.

If you need to submit a claim to the *PBM*, be sure to request an itemized bill from the *pharmacy*. The itemized bill should be submitted to the *PBM* with a completed and signed *Prescription Drug Claim Form*.

You can obtain a copy of the *Prescription Drug Claim Form* by contacting Member Services or going to CapitalBlueCross.com. Your claim will be processed more quickly when the *Prescription Drug Claim Form* is used. A separate claim form must be completed for each *member* who received *prescription drugs* or services.

You should review the instructions provided on the back of the claim form and include all of the requested information.

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

Where to Submit Prescription Drug Claims

You can submit claims with a completed *Prescription Drug Claim Form*, an itemized bill, and all required information listed above, to:

Pharmacy Services
PO Box 25136
Lehigh Valley PA 18002-5136

If you need help submitting a *prescription drug* claim, contact Member Services at the number on the back of your *ID card*.

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

All *prescription* claims must be submitted within 90 days from the date of service, except for claims from certain state and federal agencies.

Time Frames Applicable to Prescription Drug Claims

Paper claims submitted to the *PBM* are processed within 15 business days, on average, of receiving the properly completed claim. We may extend the filing/processing time 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 an extension is needed. We may also mutually agree to an extension if either of us needs more time to obtain information needed to process the claim.

Coordination of Benefits (COB)

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

Third Party Liability/Subrogation

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

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

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the

contract holder chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

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

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

Third Party Liability

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

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

Workers' Compensation Insurance

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

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

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

Motor Vehicle Insurance

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

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

your 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 *pharmacy*, 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*, health 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.

Members 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 determinations 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 determinations 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. Such services may include a 24 hour nurse line, *case management*, maternity management, and disease management programs.

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* or *cost sharing amounts* to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees on the *coverage* under this *contract*. Changes in *coverage* or in taxes or fees may result in upward adjustments in premium to reflect such changes. These 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 a 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 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, *prior authorization* 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 Pharmacy

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

Capital cannot guarantee continued access to a particular *pharmacy*. If the *member's in-network pharmacy* ceases to be in-network, *Capital*, through the *PBM*, will provide access to other *pharmacies* with similar credentials.

Clerical Error

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

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

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:

Prime Therapeutics
Mail Route: National Account
PO Box 21870
Lehigh Valley PA 18002-1870

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

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

Payments

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

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

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

Payment Recoupment

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* 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

The relationship between *Capital* and *pharmacies* is an independent contractor relationship, whether directly or indirectly. *Pharmacies* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a *pharmacy*. *Capital* shall not be liable for any claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare provider or *pharmacy*.

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

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

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital 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 provision. 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 pharmacy, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination and Autopsy

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and 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*.
- 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 *pharmacies* for *covered drugs* and/or covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network pharmacy* or a *contracting Rx entity*.

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, an email can be sent to Member Services.

Applicable Group Numbers

00528332 Rx Plan 20

January 2026

00528332	Lafayette College
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