Capital

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Rx CARD SILVER 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

Please note:

To better serve you, members with questions about their coverage should call the Dedicated Member Services phone number provided for your group at **1-855-300-2273**. For your convenience, this number is also located on your identification card.

Capital

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).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

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

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

Pour parler à un interpréter 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).

ડુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic 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).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

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

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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 provided as *benefits* under your *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
- We base our *medical necessity* determinations on whether prescription drugs and related services is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying coverage. And we don't provide them financial incentives to encourage you to use fewer covered services.
- We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet*, *Certificate 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 assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	**855.300.2273or TTY users, 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital Blue Cross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a Capital Blue Cross Connect Health and Wellness Center	Go to **CapitalBlueCrossConnect.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **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 amount upon which your *cost-sharing* amount (other than a copayment) is based, and in many cases, the maximum charge or payment level that we reimburse for *benefits* provided to you under your *coverage*.

- For *in-network pharmacies*, the allowed amount is the lesser of either 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 prescriber 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: The specified time period each year during which you can sign up for or make changes to coverage.

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. **The benefit period for this *coverage* begins January 1st and ends December 31st .**

Benefits: Those *medically necessary prescription drugs*, services, *diabetic supplies*, and other supplies covered under, and in accordance with, 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 name 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 & Therapeutics committee and found not to have significant therapeutic advantage or overall value over alternative *generic drugs*, *preferred brand drugs* or over-the-counter medications that treat the same condition, factoring in safety, efficacy and cost.

Brand Preferred Drug: A medication that has been reviewed and approved by our Pharmacy & 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: 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 of covered services that you must pay. 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 which 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 that are dispensed pursuant to a valid *prescription order* in each case for your *outpatient* use.

Deductible: The amount of the *allowed 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* immediate family or a *subscriber's domestic partner* who satisfies the applicable eligibility criteria, 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 *prescription drugs.* These drugs represent the current clinical judgment of *physicians* and other experts in the treatment of disease and preservation of health.

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 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.

Group Policy/Contract: The legal agreement between the *contract holder* and us for administration and coverage of *benefits*.

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, domestic partner, parent, step-parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child, step-child, grandparent, or grandchild.

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.
- It is not investigational in itself, but would not be *medically necessary* except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records;
- The protocol(s) pursuant to which the treatment or procedure is to be delivered;
- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure;
- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;

- Regulations and other official actions and publications issued by the federal government; and
- The opinion of a third party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Medical Necessity (Medically Necessary): Means the following:

- Services or supplies that a *physician* exercising prudent clinical judgment would provide to a *member* for the diagnosis and/or direct care and treatment of the *member's* medical condition, disease, illness, or injury that are necessary.
- In accordance with generally accepted standards of good medical practice.
- Clinically appropriate for the *member's* condition, disease, illness or injury.
- Not primarily for the convenience of the *member* and/or the *member's* family, *physician*, or other 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 for the purpose of improving 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* in accordance with 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 with, directly or indirectly, 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 rendered to such a *member*.

Over-The-Counter (OTC): A drug defined by the United States Food and Drug Administration 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 appropriate *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 assist in the administration of the *benefits* under the *group contract*.

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

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).

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

Prescription Drug: Any FDA-approved medication 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 *prescriber*.

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 determine *benefit coverage* and *medical necessity* based on clinical practice guidelines, with a requirement that specific criteria are met.

Provider: A *hospital*, *physician*, pharmacy, prescriber, 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 thirty (30) day supply per *prescription order*.

Retail Pharmacy: Any *pharmacy* that is 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 the following:

- Covered services under this *Benefits Booklet* that typically would be provided absent an a*pproved clinical trial*.
- Services and supplies required solely for the provision of the *investigational* drug, biological product, device, medical treatment or procedure.
- The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.
- The services and supplies required for the diagnosis or treatment of complications.

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 designated by us to dispense specialty prescription drugs.

Specialty Pharmacy: A *retail pharmacy* contracted with and designated 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.

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 the *benefits* provided under this *coverage* with us.

You should show your ID card and any other ID cards for other coverage **each time you obtain *prescription drugs* and related services**. *Pharmacists* use the information from your ID card to submit *claims* for processing and 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 physicians with a reference list of preferred medications for cost-effective prescribing. The *formulary* is updated by our Pharmacy and Therapeutics committee on a quarterly basis or when new generic or brand name medications become available and as discontinued drugs are removed from the marketplace.

The *formulary* provides you access to all covered drugs, whether they are designated *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 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*. Please see the **Summary of Restrictions** section for specific pharmacy network benefits (i.e. use of a Weis pharmacy) or other network parameters that applies to your *coverage*.

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 have the option to visit an *out-of-network retail pharmacy*, but it generally will cost you more.

Specialty Pharmacy. If you use select *specialty prescription drugs* as referenced 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.

Because *in-network pharmacies* agree to accept our payment for covered *benefits* - together with any applicable *cost sharing amounts* that you are obligated to pay under the terms of this *coverage* - as payment in full, you can maximize your *coverage* and minimize your out-of-pocket expenses by using an *in-network pharmacy*.

All *in-network pharmacies* must seek payment, other than *cost sharing amounts*, from us through the *PBM*. ***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 seek payment from you for noncovered *prescription drugs* and services, including specifically excluded *prescription drugs* and services, or services in excess of quantity/day supply maximums. The *in-network pharmacy* must inform you prior to providing the noncovered *prescription drugs* and/or services that you may be liable to pay for these *prescription drugs* and/or services, and you must agree to accept this liability.

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*. To find an *in-network pharmacy*, you can go to CapitalBlueCross.com or call Member Services. You will find your number on the back of your *ID card*.

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

An *out-of-network pharmacy* is a *pharmacy* that does not contract directly or indirectly, us or our *PBM* to provide *benefits* to you.

Prescription drugs and/or services provided by *out-of-network pharmacies* may require you to pay higher *cost sharing amounts* or may not be covered. If such *prescription drugs* and/or services are covered, *benefits* will be reimbursed based on the *allowed amount* applicable to this *coverage* with us.

You may be responsible for 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 between the *pharmacy's* charge for a *prescription drug* and/or service and the *allowed amount* 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. In addition, all payments are made directly to the *subscriber*. Additional information on balance billing charges can be found in the **Cost Sharing Descriptions** section.

Retail Dispensing Benefits

To receive retail dispensing benefits, *you* should present your *member ID card* to the *in-network pharmacy*. For *covered drugs* obtained from an in-network retail 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. For *covered drugs* dispensed by an *out-of-network pharmacy*, or for *covered drugs* purchased without the *member ID identification card*, to be reimbursed you must submit a claim for payment by using a prescription drug claim form that you can access at CapitalBlueCross.com. Please see the **Summary of Restrictions** section for specific pharmacy network benefits (i.e. use of a Weis pharmacy) or other network parameters that applies to your *coverage*.

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

(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.

Home Delivery Dispensing Benefits

If you currently receive your maintenance medications from a non-Weis Pharmacy location, your prescription will be covered by *Capital* for the first 2 fills of the medication. After 2 fills at a non-Weis Pharmacy location, the maintenance medication will only be covered by *Capital* if filled via Weis Central Pharmacy mail order or at a local Weis Pharmacy. The 2 fill limit for maintenance medications filled at a non-Weis Pharmacy location will begin accumulating starting 4/1/22.

For more information please go to weismarkets.com/associaterx or contact Weis Central Pharmacy:

Contact Information		
Address	**Hours**	**Phone**
Weis Markets Central Pharmacy 16 Industrial Park Road Milton, PA 17847	Monday – Friday 8:00am-4:30pm	**Toll-Free** 1-833-742-6500 - **Fax** 570-989-9233

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 require select specialty prescription drugs must use the **specialty medication preferred network** designated by us in order to receive *benefits* under this coverage. 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 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 additional 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 participating 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 or your authorized representative 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 as long as there is sufficient information to process the request. If additional 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 as long as there is sufficient information to process the request. If additional information is required, 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 standard or expedited 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 utilize 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.

Review of an Exception Denial by an Independent Review Organization (IRO)

If we deny your standard or expedited nonformulary exception appeal, you or your authorized representative may ask for a second review of the decision (i.e., an external review request) by an IRO. You or your authorized representative may make an external review request by calling us at the following number:

855.500.CARE (2273)

Please include in your external review request the reason(s) you disagree with our nonformulary exception request denial.

If the original internal nonformulary exception request was a standard exception request, the IRO will review and make a decision no later than 72 hours from our receipt of the external review request, as

long as there is sufficient information to process the review. If additional information is necessary to process the request, the decision will be made no later than 72 hours from when sufficient information is received.

If the original internal nonformulary exception request was an expedited review request, the IRO will review and make a decision no later than 24 hours from our receipt of the external review request, as long as there is sufficient information to process the request. If additional information is necessary to process the request, the decision will be made no later than 24 hours from when sufficient information is received.

The IRO will notify you and/or your authorized representative verbally of its decision and will provide a written decision within 48 hours after the verbal notice has been given. If the IRO decision grants the nonformulary exception request, the nonformulary drug will be covered for the duration of the prescription, including any refills.

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 as 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

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***
Coinsurance			
• *Generic Preferred Drug*	20% coinsurance with $10 minimum	Not Covered	20% coinsurance with $10 minimum
• *Generic Nonpreferred Drug*	20% coinsurance with $10 minimum	Not Covered	20% coinsurance with $10 minimum
• *Brand Preferred Drug*	25% coinsurance with $20 minimum	Not Covered	25% coinsurance with $20 minimum
• *Brand Nonpreferred Drug*	35% coinsurance with $25 minimum	Not Covered	35% coinsurance with $25 minimum
***Coinsurance* for Contraceptives (Self-Administered)**			
• *Generic Preferred Drug**	Not Applicable	Not Covered	Not Covered
• *Generic Nonpreferred Drug**	Not Applicable	Not Covered	Not Covered
• *Brand Preferred Drug*	25% coinsurance with $20 minimum	Not Covered	Not Covered
• *Brand Nonpreferred Drug***	35% coinsurance with $25 minimum	Not Covered	Not Covered

*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.

Deductible*† – Applies to *Brand Preferred and Brand Nonpreferred Drug* only.** *Copayments* and *coinsurance* do not apply to the *deductible*. ***In-Network Providers	Not Applicable		
Out-of-Network Providers	Not Covered		
• ***Preventive Drug Coverage*** (other than Prescription Contraceptives)	No Cost Share	Not Covered	No Cost Share
Out-of-Pocket Maximum*†** ***In-Network Providers	\$6,200 per *member* \$12,400 per family This *in-network provider out-of-pocket maximum* amount is combined with, and not in addition to, the *in-network provider out-of-pocket maximum* amount reflected in the Summary of Cost-Sharing – Medical Benefits. This combined *out-of-pocket maximum* amount can be satisfied with eligible amounts incurred for medical *benefits*, prescription drug *benefits*, or a combination of the two.		
Out-of-Network Providers	Not Applicable		
	The following expenses do not apply to the *out-of-pocket maximum*: • 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 *allowable amount* (*ancillary charge*) when a *generic drug* is available ; • Charges exceeding the *allowable 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.			

SUMMARY OF RESTRICTIONS			
	Retail	***Home Delivery****	***Specialty Pharmacy***
Days Supply	Up to 90 days	N/A	Up to 30 days
Pharmacy Network	Weis Pharmacy If there is not a Weis Pharmacy within a 20-mile radius, you may have your prescription drugs dispensed at an in-network retail pharmacy designated by the *contract holder*. If there is not a Weis Pharmacy or an in-network designated pharmacy, you may use Capital's Broad Plus retail pharmacy network to fill your scripts or choose to have your prescription drugs mailed to your home free of charge from a Weis Pharmacy. If you are outside the area for extended travel or another reason, you may use Capital's Broad Plus retail pharmacy network to fill your scripts.		
Formulary	Advantage		
Ample Day Supply Limit	*Prescription drugs* 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. (Opioid medications will only be dispensed if you have used 83% of the previous supply). Retail ample days' supply limit is 60% if the Retail Pharmacy chooses to participate as a Home Delivery Pharmacy.		
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 is through any Weis pharmacy. If a Weis pharmacy is not available within a 20-mile radius, you may use a designated in-network retail pharmacy. If a Weis Pharmacy or an in-network designated pharmacy is not available within a 20-mile radius, you may use Capital's retail pharmacy network.		
Mandatory Generic Substitution Policy	If a *generic drug* is available and you request the brand-name drug, you must pay the cost difference between the brand-name drug and its generic cost (*ancillary charge*). You also must pay the applicable brand *copayment* or *coinsurance*, 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 *generic drug* equivalent.		
Medication Synchronization	If you take 2 or more maintenance medications, you may obtain partial supply of each medication up to 3 times a year at Retail Pharmacies for medication synchronization purposes.		

Split Fill	To minimize waste and reduce your costs for certain pharmacy-dispensed specialty drugs that have a high potential for adverse side effects, we will "split fill" (i.e., partial fill) select specialty drugs for up to three months when you are new to treatment. New to treatment means, you receive a prescription of a select drug and have had no claims history of the drug in the past 120 days. The goal is to confirm effectiveness and tolerance before you receive a full supply. Specialty drugs selected for this program are noted in the formulary and in the Guide to Prescription Drug Benefits on [CapitalBlueCross.com]. The select drugs are subject to change at Capital Blue Cross' discretion.

SUMMARY OF BENEFITS

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 30-day supply)	**Home Delivery*** (Up to a 90-day supply)	***Specialty Pharmacy*** (Up to a 30-day supply)
Acne Products	Covered with age limit 40	Not 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	Not Covered	Not Covered
Diabetic Supplies	Covered	Not Covered	Not Covered
Fertility (except as mandated by law)	Covered	Not Covered	Not Covered
Nicotine Cessation Drugs **	Covered	Not Covered	Not Covered
Over-the-Counter (OTC) Products* (except as mandated by law)	Not Covered	Not Covered	Not Covered
Sexual Dysfunction Drugs (except as mandated by law)	Covered	Not Covered	Not Covered
Specialty Drugs (Self-Administered)	Certain Specialty Drugs are covered through Weis Pharmacy	Not Covered	Covered
Weight Loss Drugs	Covered	Not Covered	Not Covered
Vitamins	Covered	Not Covered	Not Covered

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

**There is no Home Delivery *coverage* under this Rx plan, except as provided in this *Benefits Booklet*

***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

COSTSHARING 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

The *allowed amount* is the amount upon which your *cost-sharing amount* (other than a *copayment*) is based, and in many cases, the maximum amount that we will pay for *benefits* under this *coverage*. Before we make payment, any applicable *cost sharing amount* is subtracted from the *allowed amount*.

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

- Deductible
- Copayments
- Coinsurance

In addition, you are responsible for paying (except where prohibited by law) any:

- *Ancillary charges*, as described in the **Mandatory Generic Substitution** section.
- Balance billing charges, which *members* pay to an *out-of-network pharmacy* and which exceed the *allowed amount*.
- Services for *benefits* not provided under your *coverage*, 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 services. *Copayment* amounts may vary, depending on the type of *prescription drug* for which *benefits* are being provided.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *copayments* apply to your *coverage*.

Deductible

A *deductible* is a dollar amount that an individual *member* or a *subscriber's* entire family must incur before *benefits* are paid under this *coverage*. The *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 (2) *deductible* amounts may apply: an individual *deductible* and a family *deductible*. Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. Once the family *deductible* has been met, *benefits* will be paid for a family *member* regardless of whether that family *member* has

met his/her individual *deductible*. In calculating the family *deductible*, we will apply the amounts satisfied by each *member* towards the *member's* individual *deductible*. However, the amounts paid by each *member* that count towards the family *deductible* are limited to the amount of each *member's* individual *deductible*.

Members should refer to the **Summary of Cost Sharing and Benefits** section to determine if any *deductibles* apply to your *coverage*.

Coinsurance

Coinsurance is the percentage of the *allowed amount* payable for a *benefit* that you are obligated to pay.

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

Refer to the **Summary of Cost Sharing and Benefits** section to determine if *coinsurance* applies to your *coverage*.

Out-Of-Pocket Maximum

The *out-of-pocket maximum* is the highest *cost- sharing amount* that an individual *member* or a *subscriber's* entire family may be required to pay during a *benefit period*.

The out-of-pocket renews each benefit period. 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. In calculating the family *out-of-pocket maximum*, we will apply the amounts satisfied by each *member* toward the *member's* individual *out-of-pocket maximum*. However, the amounts paid by each *member* that count towards the family *out-of-pocket maximum* are limited to the amount of their individual *out-of-pocket maximum*. Generally, satisfaction of *out-of-pocket maximum* amounts is determined separately for *in-network* and *out-of-network providers.*

Refer to the **Summary of Cost Sharing and Benefits** section to determine *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 furnished to *members*. This amount is called the *pharmacy's* billed charge. There may be a difference between the *pharmacy's* billed charge and the *allowed amount*.

How the interaction between the *allowed amount* and the *pharmacy's* billed charge affects the payment for *benefits* and the amount you will be responsible to pay a *pharmacy* varies depending on whether the *pharmacy* is an *in-network pharmacy* or an *out-of-network pharmacy*.

- For *in-network pharmacies*, the *allowed amount* for a *benefit* is set by the *provider's* contract. These contracts also include language whereby the *pharmacy* agrees to accept the amount paid by us, minus any *cost-sharing amount* due from you, as payment in full.
- 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 are also responsible for paying 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 subject to 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 if a) they are *medically necessary,* b) they are prior authorized (if required) by us and/or our designee, and c) if you are actively enrolled at the time of the services.

It is important to refer to the Summary of Cost Sharing and Benefits section to determine whether a *prescription drug*, a therapeutic class of *prescription drugs*, and/or a service is a covered *benefit.* Also reference the Summary of Cost-Sharing and Benefits section to determine the cost sharing amounts you are responsible for paying to *pharmacie*s, and to determine whether any *benefit* limitations/maximums apply to this *coverage*.

Benefits for *prescription drugs* include *prescription drugs* dispensed for the *outpatient* use of you. You may purchase *prescription drugs* at Weis pharmacies or at a designated in-network *retail pharmacy* if a Weis pharmacy is not available to you.

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 designated 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 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. All *prescription drugs* are subject to availability at the *retail* or *specialty pharmacy*.
6. Immunization agents for Preventive Drug Coverage are available at in-network pharmacies that are licensed to administer immunizations.
7. Select *specialty prescription drugs* will be subject to dispensing only through a designated *specialty pharmacy* unless otherwise approved by us.
8. *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.
9. We reserve the right to determine the reasonable supply of any *prescription drug* based on standards of good pharmaceutical practice.
10. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for 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 its sole discretion, is a reasonable per prescription or per day supply for *retail dispensing or specialty pharmacy* dispensing.
11. Certain *prescription drugs* require *prior authorization* for coverage prior to the delivery of *covered drugs*.
12. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are subject to step therapy.
13. *Members* are required to have their maintenance *prescription drugs* dispensed through a Weis Pharmacy or through a Weis Central Fill Mail Order facility after a two-fill maximum (lifetime max) at a non-Weis *pharmacy*. Please see weismarkets.com/associaterx for additional information.

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	• Services or supplies that we consider to be *investigational*, except routine costs associated with a*pproved Clinical Trials* *Routine Costs for Clinical Trials* do not include any of the following and are therefore excluded from *coverage*: • The investigational drug, biological product, device, medical treatment, or procedure itself, unless otherwise covered under an agreement between a *provider* and *Capital* (or other Blue plan) • Items and services that are provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient • 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	• Court ordered services when not *medically necessary* or not a covered *benefit*
Eligibility	• Services incurred prior to your *effective date of coverage* • Services incurred after your termination date of *coverage* except as provided for in this *Benefits Booklet*
Experimental or Investigational	• Services or supplies considered to be *investigational,* except where otherwise required by law
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Services not permitted by state law • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by <u>our</u> Medical Director(s) or his/her designee(s)
Medicare	• Items or services paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws, for any *member* who is enrolled in Medicare. This exclusion does not apply to the extent the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare*.

Military Services	• Services received by veterans and active military personnel at facilities operated 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 rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • 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 *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this *Benefits Booklet*
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared. War is a hostile conflict by means of armed forces, carried on between countries, states or rulers, or sometimes between political communities within the same country or state. An act of terrorism does not constitute 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 *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not you make a claim for the *benefits* or compensation under the applicable workers' compensation policy or coverage, or the applicable law.
Prescription Drugs (Drug Program)	• Drugs that do not legally require a prescription as determined by us unless payment is required by law • *Prescription drugs* that have an *over-the-counter* equivalent or *over-the-counter* alternative, except as mandated by law

- 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* required to be paid you 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 timeframe 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
    - 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

- Replacement of lost, stolen or damaged *prescription drugs,* unless otherwise approved by us
- Prescription drugs used for immunizations required 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)

All of our standard products include the full array of *Pharmaceutical Utilization Management Programs*. Under specific circumstances, groups may choose not to include all or some of the *Pharmaceutical Utilization Management Programs* described 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* acquired from in-network *retail pharmacies* and in-network *specialty pharmacies* while covered by us. Concurrent DUR alerts the *pharmacist* to clinical and plan-specific criteria/edits warranting consideration prior to dispensing. Retrospective DUR alerts the *prescriber* to potential issues that may require further assessment.

A *covered drug* filled through *retail dispensing* from an *in-network pharmacy* or the designated in-network *specialty 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 assists in identifying any potential drug interactions, duplicate drug therapy, drug dosage and duration issues, drug misuse, drug over utilization, less than optimal drug utilization, and drug abuse. If a potential problem is identified, the *prescriber* will be notified to further assess and make any necessary changes in therapy or when appropriate and applicable. Interventions may include limiting access to a *prescriber* and/or dispensing *pharmacy* under appropriate circumstances

Investigational Treatment Review

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

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

Prior Authorization

To promote appropriate utilization, 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 designated 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 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 initiate a *prior authorization* request by going to **CapitalBlueCross.com** or calling Member Services. You will find their number on the back of your ID card. *In-network providers* may assist 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 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 designated 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 designated 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.

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

These *prescription drugs* are designated 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 timeframe.

THERE IS A LIMITED PERIOD OF TIME TO SUBMIT AN *ENROLLMENT APPLICATION* FOR INITIAL ENROLLMENT AND ENROLLMENT CHANGES. *SUBSCRIBERS* SHOULD CONSULT WITH THE *CONTRACT HOLDER* TO DETERMINE THE SPECIFIC TIMEFRAMES APPLICABLE TO THEM.

SUBSCRIBERS WHO FAIL TO SUBMIT AN *ENROLLMENT APPLICATION* WITHIN THESE SPECIFIC TIMEFRAMES MAY NOT BE ALLOWED TO ENROLL THEMSELVES AND/OR THEIR NEWLY ELIGIBLE *DEPENDENTS* UNTIL THE NEXT *ANNUAL ENROLLMENT* PERIOD. *SUBSCRIBERS* SHOULD REFER TO THE TIMELINES FOR SUBMISSION OF ENROLLMENT APPLICATIONS SECTION.

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, sex, gender identity or sexual orientation; or (iii) health status-related factors pertaining to the *subscriber* or *member*. Factors include health status, medical condition, claims experience, receipt of 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 compliance with any probationary or waiting period established by the *contract holder*.

Dependent – Spouse

An individual must be the lawful spouse of the *subscriber* to enroll in this *coverage* as a *dependent* spouse.

We reserve the right to require that a spouse of a *subscriber* provide documentation demonstrating marriage to the *subscriber*, including, but not limited to, marriage certificate, court order or joint statement of common law marriage as determined by us.

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 demonstrates 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,* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A child legally adopted by or placed for adoption with the *subscriber,* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A ward (a child for whom the *subscriber,* or 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 under this *coverage* as a *dependent* child with a disability. The child must meet all of the following criteria:

- A birth child, adopted child, or ward of the *subscriber,* or 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 by reason 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,* or *subscriber's* spouse, or the *subscriber's* domestic partner for support and maintenance, provided that all the following are true:
  - 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.
  - The *subscriber* provides related information as otherwise requested by us, but not more frequently than annually.

Extension of Eligibility for Students on Medically Necessary Leave of Absence

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

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

- 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 submit 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 submit the following forms to us:

- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* has been placed on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* is no longer on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the *dependent* has reenrolled as a full-time student for the first term or semester starting 60 or more days after the *dependent's* release from active duty.

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

Enrollment

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

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

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*.

However, we will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to 60 days after the *member* is eligible for *coverage* under the *group contract* or as allowed by law. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to us.

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

Initial Enrollment

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

Newly Eligible Members

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

Subscriber

A new *subscriber* may enroll with us for *coverage* after becoming eligible, even though a *group enrollment period* is not in progress. *Subscribers* must immediately submit an *enrollment application* through the *contract holder* to ensure that they enroll within the required timeframes. Newly eligible *subscribers* should consult with the *contract holder* to determine the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section 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 application must be made through the *contract holder* within the required timeframes to add the newborn child as a *dependent*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling a newborn as a *dependent*. Refer to the **Timelines for Submission of Enrollment Applications** section for more details.

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

Life Status Change

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

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

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

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

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

Group Enrollment Period

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

Effective Date of Coverage

Initial and Newly Eligible Members

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 their *contract holder* for details regarding specific *effective dates of coverage*. These requirements are also described in the *group policy*.

Life Status

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

- The date of birth, adoption, or placement for adoption.
- The date specified in the legal custody order, in the case of a *ward*.
- The date of marriage.
- The date of attaining eligibility as a domestic partner.
- The first date after loss of other health insurance coverage.

- First day of the month following enrollment after an individual loses other minimum essential coverage.

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

TERMINATION OF COVERAGE

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

Termination of Group Contract

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

Termination of Coverage for Members

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

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

- *Subscriber* - *Coverage* ends on the date a *subscriber* is no longer employed by, or member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for all of the *subscriber's dependents* is also terminated.
- *Dependent* Spouse - *Coverage* of a *dependent* spouse ends on the date 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 **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Child Age 26 or Older with a Disability – *Coverage* of a *dependent* child age 26 or older with a disability ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* child with a disability.

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

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

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

CONTINUATION OF COVERAGE AFTER TERMINATION

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

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

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 determine 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. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

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 be required to pay for the *prescription drug* and/or service at the time the *prescription drug* is dispensed or at the time the service is rendered. *Out-of-network pharmacies* do not file claims on behalf of you. Therefore, you need to submit your claim to Pharmacy Services at the address list below for reimbursement.

Allowed Amount

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

Filing A Claim

When you submit a prescription to a *retail*, 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 are not required to pay.
- You have another dispute or discrepancy regarding the prescription drug *coverage*.

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

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 the following address:

Pharmacy Services
PO Box 25136
Lehigh Valley PA 18002-5136

Members who need help submitting a *prescription drug* claim can contact Member Services at the number on the back of their *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 with the exception of claims from certain state and federal agencies.

Time Frames Applicable to Prescription Drug Claims

Paper claims submitted to the *PBM* are processed within 15 business days, on average, of receiving the properly completed claim. We may extend the filing/processing timeframe period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if an extension is needed. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

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

Third Party Liability/Subrogation

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

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

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to

bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

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

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

Third Party Liability

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

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

Workers' Compensation Insurance

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

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

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

Motor Vehicle Insurance

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

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.*

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

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

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

To Appeal an Adverse Benefit Determination

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

Internal Appeal Process

Whenever 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 a 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. The appeal must be received by us within 180 days after you received notice of the adverse benefit determination. Your appeal must be sent to:

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

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

In reviewing the appeal, we will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination*.* You may contact us at **800.962.2242** (TTY: **711**) to receive information on the internal review process and to receive

additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al **800.962.2242**.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

External Appeal Process

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on our requirements for medical necessity, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission).

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

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

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

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit 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 designate another individual to act on your behalf in filing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as your "authorized representative" or "designee" you must complete, sign, date, and return *Capital's* Member Authorization Form. You may request this form from our Member Services department at **800.962.2242** (TTY: **711**).

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 notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate 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 the *plan sponsor* of the self-funded group health plan or we may serve as the named fiduciary.

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

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 also 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 payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

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

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

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

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

Discretionary Changes by Capital

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

Capital will provide the *contract holder* with an *official notice of change* at least 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, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

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

Conformity with Statutes

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

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

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

Choice of Forum

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

Choice of Law

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

Choice of 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 during the term of the *member's Capital* enrollment 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 Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this program that is administered by *Capital* and offered to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. The *group contract* is made up of four different documents: the *group policy/contract,* the *group application,* the *enrollment applications*, and this *Benefits Booklet*. If there is a conflict of terms between the *group policy/contract* and the *Benefits Booklet*, the terms of the *group policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

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

Failure to Perform Due to Acts Beyond Capital's Control

The obligations of *Capital* 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 on account 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 to enforce any provision of the *group contract* shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, 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 default. Moreover, payment of a claim does not waive our right to deny *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:

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

Applicable Group Numbers

00504309 Rx Card Plan 8 and Rx Card Plan 11

March, 2024