Capital BLUE

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Benefit Highlights
PPO Plan
Berks County School Districts Health Trust

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***Non-Participating Providers***
Deductible (per benefit period)	$350 per member $700 per family	$700 per member $1,400 per family
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$15 copayment per visit	20% coinsurance
• **Specialist Office Visit**	$30 copayment per visit	20% coinsurance
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$40 copayment per visit	
• **Inpatient** (Per Admission)	Not Applicable	50% coinsurance
• **Outpatient Surgery Copayment** (facility)	Not Applicable	50% coinsurance
Coinsurance	Not Applicable	20% coinsurance
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER), and Prescription Drug* for Participating Providers only).	$6,350 per member $12,700 per family	$1,500 per member $3,000 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Non-Participating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
• Adult Preventive Care		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
• Diagnostic Mammogram		Covered in full after deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		Covered in full after deductible	50% coinsurance after deductible
Acute Inpatient Rehabilitation		Covered in full after deductible	50% coinsurance after deductible
Skilled Nursing Facility	100 days/benefit period	Covered in full after deductible	50% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		Covered in full after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		Covered in full after deductible	20% coinsurance after deductible
• Laboratory		Covered in full after deductible	20% coinsurance after deductible
• Medical tests		Covered in full after deductible	20% coinsurance after deductible
Outpatient Surgery		Covered in full after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		Copayment applies	20% coinsurance after deductible
• Occupational Therapy	12 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Speech Therapy	12 visits/benefit period	Copayment applies	20% coinsurance after deductible
• Respiratory Therapy		Copayment applies	20% coinsurance after deductible
• Manipulation Therapy		Copayment applies	20% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
• Outpatient Services		Copayment applies	20% professional and 50% facility coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full after deductible	20% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Covered in full, waive deductible	20% professional and 50% facility coinsurance after deductible
Home Health Care Services		Covered in full after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		Covered in full after deductible	20% coinsurance after deductible
Prosthetic Appliances		Covered in full after deductible	20% coinsurance after deductible
Orthotic Devices		Covered in full after deductible	20% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. *Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*

SUMMARY OF BENEFITS	Amounts Members Are Responsible For:			
PRESCRIPTION DRUG DEDUCTIBLE Per benefit period*	$100 per member, retail only			
	Retail Pharmacy (up to a 30-day supply)	**Mail Service Pharmacy** (up to a 90-day supply)	**Specialty Pharmacy** (up to a 30-day supply)	**Specialty Pharmacy** (over 30-day supply)
PRESCRIPTION DRUG TIER	**BENEFIT**			
Generic Preferred Prescription Drugs	$5 copayment	$10 copayment	$5 copayment	$3.33 copayment
Generic Non-Preferred Prescription Drugs	$5 copayment	$10 copayment	$5 copayment	$3.33 copayment
Brand Preferred Prescription Drugs	$35 copayment	$70 copayment	$35 copayment	$23.33 copayment
Brand Non-Preferred Prescription Drugs	$70 copayment	$140 copayment	$70 copayment	$46.67 copayment
Network	CVS Caremark National Pharmacy Network			
PRESCRIPTION DRUG TIER (Contraceptives)	**BENEFIT**			
Generic Prescription Drugs	$0 copayment	$0 copayment	Not covered	Not covered
Select Brand Prescription Drugs**	$0 copayment	$0 copayment	Not covered	Not covered
Brand Preferred Prescription drugs	$35 copayment	$70 copayment	Not covered	Not covered
Brand Non-Preferred Prescription drugs	$70 copayment	$140 copayment	Not covered	Not covered
FORMULARY SYSTEM	Open			
UTILIZATION PROGRAM	**BENEFIT**			
Generic Substitution Program	**Voluntary Generic Substitution Program** - The member pays the applicable copayment/coinsurance for a generic drug and for a brand drug, even if an approved generic drug equivalent is available and regardless of whether the physician or member requested such brand drug be dispensed.			
Specialty Pharmacy	**For most specialty medications, coverage is available only when dispensed by Accredo Health Group, Inc.**			
Quantity Level Limits (per prescription, day supply or copayment)	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**			
Prior Authorization and Enhanced Prior Authorization	**Applicable to selected drugs. Refer to the Capital BlueCross formulary or go to www.capbluecross.com.**			

Inpatient admissions as well as certain other services and equipment may require Preauthorization.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have.

**Select Brands include contraceptives for which there is no generic equivalent.

Participating providers and pharmacies agree to accept our allowance as payment in full—often less than their normal charge. If you visit a non-participating provider or pharmacy, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's or non-participating pharmacy's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to non-participating pharmacies are not applied to the out-of-pocket maximum. In certain situations a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager. Accredo Health Group, Inc. is the exclusive vendor for specialty prescription drugs. On behalf of Capital BlueCross, Accredo Health Group, Inc. assists in the delivery of specialty medications directly to our Members. Accredo Health Group, Inc. is an independent company.

For more information or to locate a participating provider, visit www.capbluecross.com.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size >51.

Capital BlueCross

Rx

Berks County School Districts Health Trust

Premium Card Plan

HIGHLIGHTS	AMOUNTS YOU ARE RESPONSIBLE FOR:			
	Retail (up to a 30-day supply)	Mail Service (up to a 90-day supply)	Specialty Pharmacy (Prescription orders written for up to a 30 day supply)	Specialty Pharmacy (Prescription orders written for over a 30 day supply)
DEDUCTIBLE				
Per benefit period*	$100 per member, retail only			
OUT-OF-POCKET MAXIMUM				
When the out-of-pocket maximum is reached, the Plan pays 100% until the end of the benefit period	None			
PRESCRIPTION DRUG TIER	**BENEFIT**			
Generic prescription drug	$5 copayment	$10 copayment	$5 copayment/30 day supply	$3.33 copayment/30 day supply
Brand Preferred prescription drug	$35 copayment	$70 copayment	$35 copayment/30 day supply	$23.33 copayment/30 day supply
Brand Non-Preferred prescription drug	$70 copayment	$140 copayment	$70 copayment/30 day supply	$46.67 copayment/30 day supply
PRESCRIPTION DRUG TIER (Contraceptives)	**BENEFIT**			
Generic Prescription Drugs	$0 copayment	$0 copayment	Not covered	Not covered
Select Brand Prescription Drugs**	$0 copayment	$0 copayment	Not covered	Not covered
Brand Preferred prescription drugs	$35 copayment	$70 copayment	Not covered	Not covered
Brand Non-Preferred prescription drugs	$70 copayment	$140 copayment	Not covered	Not covered
PRESCRIPTION CATEGORY	**BENEFIT**			
Contraceptives	Covered	Covered	Not covered	Not covered
Fertility Drugs ($2,500 maximum benefit limit per member)	Covered	Covered	Covered	Covered
Sexual Dysfunction Drugs	Covered	Covered	Not covered	Not covered
Weight Loss Drugs	Covered	Covered	Not covered	Not covered
Non-Specialty Injectables (self-administered)	Covered	Covered	Not covered	Not covered
Specialty Drugs (self-administered)	Covered	Not covered	Covered	Covered
Nicotine Cessation Products (prescription)	Covered	Covered	Not covered	Not covered
Vitamins (prescription, non-prenatal)	Covered	Covered	Not covered	Not covered
Prenatal Vitamins (prescription)	Covered	Covered	Not covered	Not covered
Anti-Flu Therapies	Covered	Not covered	Not covered	Not covered
Diabetic Supplies	Covered	Covered	Not covered	Not covered
Topical Retinoid (Acne) Products	Covered	Covered	Not covered	Not covered
Over-the-Counter Equivalents	Not covered	Not covered	Not covered	Not covered
UTILIZATION PROGRAM	**BENEFIT**			
Generic Substitution Program	**Voluntary Generic Substitution Program** - The member pays the applicable copayment/coinsurance for a generic drug and for a brand drug, even if an approved generic drug equivalent is available and regardless of whether the physician or member requested such brand drug be dispensed.			
Quantity Level Limits (per prescription, per day supply or per copayment)	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.			
Prior Authorization	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.			
Enhanced Prior Authorization	**Applicable to selected drugs. Please refer to the Capital BlueCross formulary or go to** www.capbluecross.com.			

This is not a Contract. Programs are subject to change. This information highlights benefits, limitations and exclusions of the prescription drug coverage and is not intended to be a complete list or complete description of available services. The terms and conditions of coverage shall be governed solely by the contract issued to the group. Contact your employer, marketing representative, or broker for additional benefit details.

*Refer to your Certificate of Coverage or contact your employer for the applicable benefit period.

****Select** Brands include contraceptives for which there is no generic equivalent.

The pharmacy network includes many chain and independent retail pharmacies nationwide. Visit www.capbluecross.com to find a participating pharmacy. **Curascript® is the exclusive vendor for specialty prescription drugs.**

Participating pharmacies agree to accept our allowance as payment in full, often less than their normal charge. If you use a non-participating pharmacy, you are responsible for paying the difference between what the non-participating pharmacy's charges and the allowable amount in addition to any deductible, coinsurance or copayment. You will also need to complete and submit a claim form for reimbursement. Deductibles, any differences paid between brand drug and generic drug prices, and any balances paid to non-participating pharmacies are not applied to the out-of-pocket maximum.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage.

On behalf of Capital BlueCross, CVS/Caremark assists in the administration of our prescription drug program. CVS/Caremark is an independent pharmacy benefit manager.

On behalf of Capital BlueCross, CuraScript, Inc. assists in the delivery of specialty medications directly to our Members. Curascript is an independent company.

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company. Both companies are subsidiaries of Capital BlueCross and are independent licensees of the BlueCross BlueShield Association. *Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*

Rx *Premium Card Plan* – Standard Benefit Limitations and Exclusions

The group contract will contain standard benefit limitations and exclusions.

LIMITATIONS

Limitations to benefits set forth in the group contract include:

1. A participating pharmacy or non-participating pharmacy need not dispense a prescription order that for any reason, in its professional judgment, should not be filled.
2. A member may purchase a non-preferred brand drug if it could be used to treat his or her condition. If, however, a member purchases a non-preferred brand drug, the member may be required to pay a higher copayment/coinsurance, based on the member's benefit plan and as indicated in the Certificate of Coverage.
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 (1) year after the date of the original prescription order. When a prescription order is written for a prescription drug that has previously been dispensed to a member or a prescription order is presented for a refill, the prescription drug will be dispensed only at such time as the member has used sixty percent (60%) of the previous supply dispensed through the designated mail service pharmacy or seventy-five (75%) of the previous supply dispensed through a retail pharmacy or specialty pharmacy in accordance with the associated prescription order.
4. Certain prescription drugs will not be available for mail service dispensing due to safety or quality concerns. Such prescription drugs will be subject to retail dispensing or specialty pharmacy dispensing only.
5. All prescription drugs are subject to availability at the retail pharmacy, specialty pharmacy, or mail service pharmacy.
6. Select specialty prescription drugs will be subject to dispensing only through a designated specialty pharmacy.
7. Prescription drugs classified by the federal government as narcotics may be subject to dispensing or dosage limitations based on standards of good pharmaceutical practice or state or federal regulations.
8. Capital reserves the right to determine the reasonable supply of any prescription drug based on standards of good pharmaceutical practice.
9. Certain prescription drugs, which are dispensed pursuant to a prescription order for the outpatient use of the member, are subject to quantity limits. Benefits for these prescription drugs shall be available based on the quantity which Capital will determine, in its sole discretion, is a reasonable per prescription or per day supply for retail dispensing, specialty pharmacy dispensing, or mail service dispensing.
10. Certain prescription drugs require prior authorization for coverage prior to the delivery of covered drugs.

EXCLUSIONS

Except as specifically provided in the Contract and in addition to any limitations set forth in the Contract, no benefits shall be provided for:

1. Which are not medically necessary as determined by Capital or its designee;
2. Unless otherwise set forth in the group contract, drugs that do not legally require a prescription as determined by Capital;
3. For prescription drugs that have an over-the-counter equivalent;
4. For devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for diabetic supplies;
5. For the administration or injection of prescription drugs;
6. For prescription drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;
7. For allergy serums, desensitization serums, venom;
8. Which are considered by Capital or its designee to be experimental or investigational;
9. For any illness or injury which occurs in the course of employment if benefits or compensation are available or required, in whole or in part, under a workers' compensation policy and/or any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the member makes a claim for the benefits or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;
10. For any illness or injury suffered after the member's effective date of coverage which resulted from an act of war, whether declared or undeclared;
11. Which are received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;
12. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
13. For the cost of benefits resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used, including such benefits mandated by law) of any motor vehicle insurance policy;
14. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the contract holder is obligated by law to offer the member the benefits of this coverage as primary and the member so elects this coverage as primary;
15. For care of conditions that federal, state or local law requires to be treated in a public facility;
16. Which are court ordered services when not medically necessary and/or not a covered benefit;
17. Which are rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;
18. Which exceed the allowable amount;
19. Which are cost-sharing amounts, differences between brand drug and generic drug prices (i.e. ancillary charges), and balances paid to non-participating pharmacies required of the member under this coverage;
20. For prescription drugs that require prior authorization if prior authorization is not obtained before dispensing the prescription drugs;
21. For quantities that exceed the limits/levels established by Capital;
22. For which a member would have no legal obligation to pay;
23. Which are incurred prior to the member's effective date of coverage;
24. Which are incurred after the date of termination of the member's coverage except as provided for in the Certificate of Coverage;
25. Which are received by a member in a country with which United States law prohibits transactions;
26. For prescription drugs utilized primarily to enhance physical or athletic performance or appearance;
27. For clinical cancer trial costs (e.g., drugs under investigation; patient travel expenses; data collection and analysis services), except for costs directly associated with medical care and complications, related to a Capital approved trial, which would normally be covered under standard patient therapy benefits;
28. For travel expenses incurred in conjunction with benefits unless specifically identified as a covered benefit elsewhere in the Certificate of Coverage;
29. For all prescription drugs and over-the-counter drugs dispensed during travel by a physician employed by a hotel, cruise line, spa, or similar facility;
30. For durable medical equipment;
31. For blenderized baby food, regular shelf food, or special infant formula;
32. For immunization agents, biological sera, blood, blood products;
33. For requests for reimbursement of covered drugs submitted after the allowed timeframe for reimbursement;
34. For all prescription drugs and over-the-counter drugs dispensed in a physician's office or by a facility provider;
35. For prescription drugs utilized to promote hair growth;
36. For prescription drugs utilized for cosmetic purposes;
37. For injectable medications that cannot be self-administered;
38. For coverage through coordination of benefits;
39. Which are received through the designated and/or non-participating mail service pharmacy for mail service dispensing and submitted for reimbursement under retail dispensing benefits;
40. Which are received through a retail pharmacy for retail dispensing and submitted for reimbursement under mail service dispensing benefits;
41. For prescription drugs utilized in connection with non-covered medical services; and
42. For any other prescription drugs, service or treatment, except as provided in the Certificate of Coverage.

Capital BLUE

Preauthorization Program

Comprehensive, PPO

To receive the highest level of *benefits* it is sometimes necessary to obtain *preauthorization* for services.

SERVICES REQUIRING PREAUTHORIZATION

The following medical care services and procedures require *preauthorization*:

- All non-emergency *inpatient* admissions including acute care, long-term acute care, *skilled nursing facilities,* and *rehabilitation hospitals.* Emergent admissions require notification within 48 hours;
- Observation Care greater than 48 hours;
- Behavioral health (mental health care/substance abuse)- all *inpatient* admissions, partial hospitalization, and intensive *outpatient* programs (Behavioral health phone numbers are listed on the *member's* ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Non-emergent air and ground ambulance transports;
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to $500 dollars. All DME rental items that are on the *preauthorization* list, regardless of price per unit, require *preauthorization*;
- Enhanced external counterpulsation (EECP);
- All testing for genetic disorders except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- All high-tech, non-emergency imaging procedures including: MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography), CT (computerized tomography), PET (positron emission tomography) scans, SPECT (single proton emission computerized tomography) scans;
- Home health care;
- Home infusion therapy;
- Specialty Medical Injectable Medications;
- Any reconstructive or cosmetic surgery, therapy or procedure for the treatment of a medical disease, injury, accident or congenital anomaly, except for reconstructive surgery incident to a mastectomy in a manner determined in consultation with the attending physician and the patient;
- Laser treatment of skin lesions;
- Manipulation therapy (chiropractic and osteopathic);
- Office surgical procedures that are performed in a facility, including but not limited to:
  - Arthrocentesis;
  - Aspiration of a joint;
  - Colposcopy;
  - Electrodessication condylomata (complex);
  - Excision of a chalazion;
  - Excision of a nail (partial or complete);
  - Enucleation or excision of external thrombosed hemorrhoids;
  - Injection of a ligament or tendon;
  - Interocular injection for retinal pathology;
  - Oral Surgery;
  - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
  - Proctosigmoidoscopy/flexible Sigmoidoscopy;
  - Removal of partial or complete bony impacted teeth (if a benefit);
  - Repair of lacerations, including suturing (2.5 cm or less);
  - Vasectomy;
  - Wound care and dressings (including outpatient burn care)
- *Outpatient* surgeries - All potentially reconstructive/cosmetic or investigational surgeries/procedures;
- Pulmonary rehabilitation programs;
- Rehabilitation therapies including physical medicine, occupational therapy and respiratory therapy;
- Transplant evaluation and services. *Preauthorization* will include referral assistance to the Blue Quality Centers for Transplant network if appropriate;
- Bio-engineered or biological wound care products;
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Hyperbaric Oxygen Therapy (non-emergent);
- Sleep studies for diagnosis and medical management of obstructive sleep apnea syndrome;
- Radiofrequency Ablation for Pain Management:

Preauthorization requirements do not apply to services provided by a *hospital* emergency room *provider.* If an *inpatient* admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the *hospital* is a *participating provider*, the hospital is responsible for performing the notification. If the *hospital* is a *non-participating provider*, the *member* or the *member's* responsible party acting on the *member's* behalf is responsible for the notification.

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

The *member's identification card* will show if *preauthorization* is required before receiving the listed services or supplies.

If *preauthorization* is required, *members* should present their *identification card* to their health care *provider* when medical services or supplies are requested. The *member's participating provider* will be asked to provide medical information on the proposed treatment to *Capital's* Clinical Management Department by calling **1-800-471-2242**.

If *members* use a *non-participating provider* or a *BlueCard participating provider*, it is their responsibility to obtain *preauthorization*. *Members* should call *Capital's* Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*. A *non-participating provider* may call on the *member's* behalf. However, it is ultimately the *member's* responsibility to obtain *preauthorization*.

Capital's Clinical Management Department will notify the *member's* health care *provider* and the *member* of the authorization or denial of the requested procedures, services, and/or supplies within fifteen (15) days after *Capital* receives the request for *preauthorization*. *Capital* may extend the fifteen (15)-day time period one (1) time for up to fifteen (15) days for circumstances beyond *Capital's* control. *Capital* will notify the *member* prior to the expiration of the original time period if an extension is needed. The *member* and *Capital* may also agree to an extension if the *member* or *Capital* requires additional time to obtain information needed to process the *member's preauthorization*.

Preauthorization of elective admissions and selected services should be obtained at least seven (7) days prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

Special rules apply to *preauthorization* of *urgent care* medical services.

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Capital* of the urgent medical circumstances when the *member* or the *member's provider* submit the request to *Capital's* Clinical Management Department. *Capital* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Capital's* Clinical Management Department receives the *preauthorization* request.

Members who are dissatisfied with an adverse *preauthorization* determination regarding an *urgent care* claim may submit an appeal. *Urgent care* appeals may be submitted orally by contacting *Capital's* Customer Service Department, toll-free, at **1-800-962-2242**. *Capital* will notify the *member's* health care *provider* and the *member* of the outcome of the appeal via telephone or facsimile no later than seventy-two (72) hours after *Capital* receives the appeal.

PREAUTHORIZATION PENALTY

When a procedure is not preauthorized when required, there may be a *preauthorization penalty*.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, the *allowable amount* will not be subject to reduction.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the allowable amount may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage*.

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at **1-800-962-2242** (TDD number at **1-800-242-4816**) with questions regarding the *preauthorization* of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

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