Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, Pennsylvania 17822

Marketplace Direct
Group Subscription Certificate

This Direct Access Preferred Provider Organization Contract, called Geisinger Choice PPO with no Referral, provides hospital, medical-surgical and extended benefits utilizing Preferred Provider networks to maximize benefits. Covered Services provided by Non-Preferred Providers will generally subject the Member to an additional Coinsurance liability, except for outpatient Emergency Care or when Covered Services are not available from a Preferred Provider. In such instances, coverage increases to the Preferred Provider level of coverage. In the event that the Member requires emergency care, the PPO will provide coverage at the Preferred Provider level to a Non-Preferred Provider and the Member's out-of-pocket expense will be no greater than the amount that would have been incurred if the Member had been able to choose a Preferred Provider.

This Contract utilizes Precertification procedures which must be followed in order to maximize coverage and avoid penalties.

Geisinger Quality Options, Inc. d/b/a Geisinger Choice is a Qualified Health Plan issuer in the Health Insurance Marketplace.

M-152-121-F Dev. 1/14

GEISINGER QUALITY OPTIONS, INC.
100 North Academy Avenue
Danville, PA 17822-3220

GEISINGER CHOICE PPO WITH NO REFERRAL
Marketplace Direct Group Subscription Certificate

Thank you for choosing Geisinger Quality Options, Inc. Preferred Provider Organization ("PPO").

Geisinger Quality Options, Inc. is a corporation located in Danville, Pennsylvania that offers the Geisinger Choice PPO with no Referral contract. **This contract provides hospital, medical-surgical and other benefits utilizing Preferred Provider services to maximize benefits. Generally, Covered Services provided by a Non-Preferred Provider will subject the Member to significant out-of-pocket expenses due to higher Cost Sharing and because such expenses are based on the PPO's Non-Preferred Provider Fee Schedule Amounts, except for outpatient Emergency Services or when Covered Services are not available from a Preferred Provider. This Geisinger Choice PPO contract also requires Precertification procedures, which must be followed in order to maximize coverage and avoid penalties.**

To review, the coverage provided to you is defined by the following documents:

1. The Group Subscription Certificate (the Certificate), which identifies Covered Services and the terms and conditions of coverage awarded to all Members eligible for Group coverage;

2. Amendments to the Certificate, which inform Members of any changes to Covered Services or changes to the terms and conditions of coverage;

3. Riders to the Certificate, if any, which identify Supplemental Health Services covered in addition to the services included in the Certificate;

4. The Schedule of Benefits to the Certificate, which sets forth, among other things, the Member's responsibilities for Cost Sharing such as Copayment, Deductible and Coinsurance amounts for Covered Services, including the Maximum Out-of-Pocket liability of a Member within a Benefit Period (as applicable);

5. Enrollment Application, which is the Subscriber's written request for enrollment;

6. The Group Master Policy, which is an agreement between the PPO and a Group for coverage arranged by the PPO to individuals eligible to receive health benefits through their employer; and

7. The Member's Enrollment Letter.

The PPO issues these documents in accordance with the terms of a Certificate of Authority awarded by the Pennsylvania Insurance Department and Pennsylvania Department of Health. Together, the Certificate and any Amendments, Riders (if any), Schedule of Benefits, Enrollment Application to enroll in the PPO and the Enrollment Letter constitute the entire agreement between the Subscriber named on the Schedule of Benefits and the PPO. In addition, these documents specify the coverage extended to the Subscriber and Family Dependents in consideration of the specified premiums paid by them or on their behalf. The Certificate and all Amendments, Riders (if any), Schedule of Benefits, and the Enrollment Application to enroll in the PPO, remain in effect as long as the Group Master Policy remains in effect, or until such time that a Member's coverage may be terminated in accordance with the termination provisions outlined in the Certificate.

Additional information: The PPO will provide all Members and prospective Members with any of the following information. Please call our Customer Service Team for:

- a list of the names, business addresses and official positions of the membership of the Geisinger Quality Options, Inc. Board of Directors;
- the procedures adopted to protect the confidentiality of medical records and other Member information;
- a description of the credentialing process for Preferred Health Care Providers;
- a list of the Preferred Providers affiliated with hospital Preferred Providers;
- whether a specifically identified drug is included or excluded from coverage;
- a description of the process by which coverage can be obtained for specific drugs prescribed by a Preferred Provider, drugs used for an off-label purpose, biologicals and medications not included in the 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 to the Member;
- a description of the procedures followed by the PPO to make decisions about the experimental nature of individual drugs, medical devices or treatments;
- a summary of the methods used by the PPO to reimburse for health care services; and/or
- a description of the procedures used in the PPO's quality assurance program.

For help and information: Members should call the Customer Service Team at the telephone number located on the back of the Member's Identification Card weekdays between 8 a.m. and 6 p.m. to obtain approval or authorization of a health care service or other information regarding the PPO. Members may also write to us at Geisinger Quality Options, Inc. PPO Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3226.

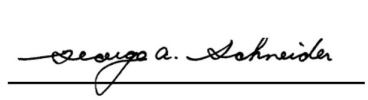
Needs of non-English speaking enrollees: if a Member who does not speak English calls the Customer Service Team for assistance, an appropriate interpreter will be provided to translate for the Customer Service Team representative and the Member. Such services will be available at no cost.

Español: Si un Cubrió a Persona que no habla inglés llama el Equipo de Servicio de atención al cliente para la ayuda, un intérprete apropiado será proporcionado para traducir para el representante del Equipo de Servicio de atención al cliente y el Cubrió a Persona. Tales servicios estarán disponibles en ningún costo.

IN WITNESS WHEREOF,

Geisinger Quality Options, Inc.
has duly executed this Certificate

Duane E. Davis, M.D.
President, Chief Executive Officer
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220



George A. Schneider, CPA
Chief Financial Officer
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220

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SECTION 1. DEFINITIONS

1. GENERAL DEFINITIONS. The following terms, when used in this Certificate and all applicable Amendments, Riders, and Schedule of Benefits, will have the meanings assigned to them below unless these terms are otherwise defined in such other applicable documents (please note that these terms will be capitalized when used in document text):

1.1 Advance Health Care Directive means a writing made in accordance with legal requirements that expresses a person's wishes and instructions for health care and health care directions when the person is determined to be incompetent and has an end-stage medical condition or is permanently unconscious. An Advance Health Care Directive could also be a writing made by a person designating an individual to make health care decisions for them should they be incapacitated or incompetent.

1.2 Ambulatory Surgical Center means a facility or portion thereof not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment. This does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

1.3 Amendment is any document that describes changes to Covered Services or changes to the terms and conditions of coverage, which have become necessary between printings of the Certificate which is executed by an officer of the PPO and is to be attached to and made a part of the Certificate.

1.4 Back Pain Management Specialist. A Back Pain Management Specialist is a specialist in the diagnosis and treatment of patients with painful and/or functionally limiting conditions who is designated by the PPO to provide clinical evaluations of Members in the Back Pain Management Program as set forth in Certificate Section 3.3.

1.5 Benefit Limit means a specific limitation on a benefit which is set forth in the Schedule of Benefits, Rider(s) and/or in the Certificate as an age requirement, dollar amount or number of services covered per Benefit Period.

1.6 Benefit Period means the period of time this Certificate is in effect as indicated on the Schedule of Benefits.

1.7 Certificate refers to this document, which is provided by the PPO to all Subscribers awarded Group coverage. The Certificate describes the Covered Services and the terms and conditions of coverage.

1.8 Certificate Effective Date means 12:01 a.m. on the date on which coverage and enrollment under this Certificate begins as specifically set forth on the Schedule of Benefits.

1.9 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time, that provides continuation coverage to Members who incur certain qualifying events (as defined under COBRA).

1.10 Coinsurance is a form of Cost Sharing (indicated as a percentage amount on the Schedule of Benefits) which requires the Member to pay a specified portion of the Preferred Provider Fee Schedule Amount or the Non-Preferred Provider Fee Schedule Amount after the Deductible has been paid by the Member or Family Unit. The Coinsurance applies towards the Maximum Out-of-Pocket amount as set forth on the Schedule of Benefits.

1.11 **Commissioner** means the Insurance Commissioner of the Commonwealth of Pennsylvania.

1.12 **Copayment** is a form of Cost Sharing which requires the Member to pay a fixed amount of money for the cost of Covered Services. Copayment amounts are set forth on the Schedule of Benefits and are due at the time and place such services are received by a Member.

1.13 **Cost Sharing** means the Copayment, Coinsurance, Deductible and any amounts exceeding the Maximum out of Pocket or Benefit Limits that a Member will incur as an expense for Covered Services. Specific Cost Sharing amounts for Covered Services can be found on the Schedule of Benefits.

1.14 **Covered Service** means:

a) a Medically Necessary (unless otherwise indicated) service which is covered by the PPO when it is listed as a Covered Service in this Certificate; or

b) any Medically Necessary Supplemental Health Services set forth in any Riders supplementing this Certificate.

1.15 **Custodial, Domiciliary or Convalescent Care** means services to assist an individual in the activities of daily living that do not require the continuing attention of skilled, trained medical or paramedical personnel.

1.16 **Customer Service Team** refers to the PPO representatives who are available to answer Member's questions and provide information regarding the PPO and coverage. The telephone number for the Customer Service Team is set forth on the back of the Member's Identification Card.

1.17 **Deductible** means a specified dollar amount for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the PPO will assume any liability for all or part of the cost of Covered Services. The Deductible applies to each Member subject to any Family Deductible set forth on the Schedule of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers, as set forth on the Schedule of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Preferred Providers or Preferred Providers do not accrue toward each other. Deductible amounts must be met every Benefit Period before the corresponding Coinsurance amount applies. Copayment amounts do not accrue toward satisfaction of any Deductible amounts. Deductible amounts apply to the Maximum Out-of-Pocket for Essential Health Benefits.

1.18 **Designated Behavioral Health Benefit Program** means a program in which the PPO manages behavioral health services (including inpatient and outpatient mental health and Substance Abuse care).

1.19 **Designated Transplant Facility** is a facility that has entered into an agreement with the PPO, the PPO's transplant subcontractor or national organ transplant network to provide transplant services when a transplant service as set forth in Section 3.33 is Medically Necessary for a Member. The Designated Transplant Facility is determined by the PPO or the PPO's transplant subcontractor and may or may not be located in the Service Area.

1.20 **Durable Medical Equipment (DME)** means equipment designed to serve a medical purpose and which is not generally useful to a person in the absence of illness or injury, is able to

withstand repeated use, is not a disposable or single patient use and is required for use in the home.

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

a) placing the health of the Member, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy;

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

Transportation and related Emergency Services provided by a licensed ambulance service shall constitute an Emergency Service if the condition is as described in this definition.

1.22 **Enrollment Application** refers to the form(s) completed by the applicant for enrollment purposes.

1.23 **Enrollment Letter**. The Enrollment Letter is a letter sent by the PPO to the Member as notification that they are an enrolled Member under the Certificate. The Enrollment Letter sets forth the Member's effective date of coverage under the PPO.

1.24 **Experimental, Investigational or Unproven Services** are any medical, surgical, psychiatric, Substance Abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices (collectively called "technologies") that are determined by the PPO to be:

a) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use (however, approval by the FDA or other federal regulatory agency does not imply that the technology is automatically considered by the PPO to be Medically Necessary or as being the accepted standard of care); or not identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Provider as being investigational, experimental, research based or educational; or

b) The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulation. Procedures and services provided as being related to an investigational technology, or rendered as part of a clinical trial or research protocol, including, but not limited to, services and procedures that would otherwise be covered, and hospital admissions solely for the purpose of providing an investigational technology, research protocol or clinical trials are NOT COVERED, regardless of whether the trial is subject to FDA oversight; or

c) The subject of a written research or investigational treatment protocol being used by the treating Provider or by another Provider who is studying the same service.

d) If the requested service is not represented by criteria a, b, or c as listed above, the PPO reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:

(i) the service has a measurable, reproducible positive effect on the health outcomes as evidenced by well-designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use; and

(ii) the proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied; and

(iii) the improvement in health outcome is attainable outside of the clinical investigation setting; and

(iv) the majority of Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and

(v) the beneficial effect on health outcomes outweighs any potential risk or harmful effects.

1.25 **Family Coverage** means the Covered Services provided under this Certificate for a Subscriber and one or more Family Dependents who are Members under the same Certificate.

1.26 **Family Dependent** means any member of the family of a Subscriber:

a) who meets all the requirements as set forth in Section 6.2 of this Certificate and any additional requirements set forth in the Group Master Policy;

b) who is enrolled under this Certificate;

c) for whom the applicable premium for Family Coverage has been paid;

d) a Family Dependent is also a Member as defined in Section 1.41 of this Certificate; and

e) a Family Dependent is also a Domestic Partner as set forth in Section 6.2.8 of this Certificate.

1.27 **Family Unit** means the Subscriber and his or her Family Dependents.

1.28 **Group** means the employer, association, union or trust through which the Subscriber is enrolled and who agrees to remit premiums for coverage payable to the PPO. The Group is identified on the Schedule of Benefits.

1.29 **Group Master Policy** means the agreement between the PPO and the Group providing for the administration of enrollment, payment of premiums, and other matters pertaining to the provision of health care benefits under the terms of this Certificate for persons who meet the requirements of the Group to participate in the Group's health benefit's plan.

1.30 **Health Care Provider or Provider** means a licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under any applicable law, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

1.31 **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** as may be amended from time to time, is a federal law including, but not limited to, the following:

a) limiting exclusions for Pre-Existing Conditions (as defined under HIPAA);

b) prohibiting discrimination against employees and dependents based on their health status;

c) guaranteeing renewability and availability of health coverage to certain employers and individuals;

d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and

e) regulating the use and disclosure of protected health information.

1.32 Hospice. The following definitions **only apply** to Hospice services.

1.32.1 **Continuous Care** means a level of continuous and uninterrupted care which is:

a) necessary due to periods of crisis resulting from a Member's deteriorating medical condition and/or the Member's family's inability to provide the level of care necessary to maintain the Member at home; and

b) provided in the Member's home by qualified professionals for a period of at least eight (8) hours until such care is deemed no longer Medically Necessary by the PPO.

1.32.2 **General Inpatient Care** means a level of care involving Hospice-supervised inpatient services in accordance with the Member's Plan of Care including, without limitation, services necessary for pain control or symptom management during one (1) or more days, including overnight stays, in an inpatient setting to include either a hospital, skilled nursing facility, or hospice inpatient facility.

1.32.3 **Hospice** means a Covered Service rendered by a Preferred Provider who is licensed as a provider of Hospice services in the Commonwealth of Pennsylvania and is a certified provider of Hospice services under Medicare.

1.32.4 **Hospice Medical Director** means a physician who is licensed in the Commonwealth of Pennsylvania to practice medicine and is employed by Hospice either directly or under contractual arrangement to provide physician services to the Hospice patient in accordance with such patient's Plan of Care.

1.32.5 **Interdisciplinary Group** means a group of Hospice employees including, but not limited to, a doctor of medicine or osteopathy, registered nurse, and a pastoral or other counselor, who are responsible for:

a) establishing the Plan of Care;

b) periodically reviewing and updating the Plan of Care;

c) providing or supervising the provision of services offered by the Hospice; and

d) developing policies regarding the day-to-day provision of care by the Hospice.

1.32.6 **Plan of Care** means a written individualized care plan which:

a) is established, maintained and reviewed at periodic intervals for the Member by the Hospice Medical Director or physician designee, the Member's physician Preferred Provider and the Interdisciplinary Group;

b) includes an assessment of the Member's needs and assignment of a level of Hospice care; and

c) details the scope and frequency of services to be provided for the Member's Terminal Illness.

1.32.7 **Respite Care** means a level of care involving Hospice-supervised inpatient services, in accordance with the Member's Plan of Care, to provide the Member's family with a reprieve from caring for the Member at home when the Member does not have any symptoms which would otherwise require inpatient services. Respite Care shall:

a) include care for one (1) or more days, including overnight stays, in an inpatient setting to include either a hospital, skilled nursing facility or a Hospice inpatient facility; and

b) not exceed five (5) days per admission.

1.32.8 **Routine Home Care** means a level of intermittent and part-time care provided in accordance with a Member's Plan of Care and rendered by qualified professionals in the Member's home. Such care shall include nursing services, social services, physical therapy, occupational therapy, speech pathology, and counseling and support services for both the Member and the Member's family.

1.32.9 **Terminal Illness** means an incurable illness or other condition with a medical prognosis of life expectancy of six (6) months or less.

1.33 **Identification Card** means the card issued by the PPO to a Member pursuant to this Certificate which is for identification purposes only. Possession of an Identification Card confers no right to Covered Services or other benefits under this Certificate. To be entitled to Covered Services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable premiums and charges under this Certificate have actually been paid.

1.34 **Legal Custody** means the legal right to make major decisions affecting the best interest of a minor including, but not limited to, medical, religious and educational decisions pursuant to 23 Pa. C.S.A. Section 5302.

1.35 **Legal Guardian or Legal Guardianship** means the appointment of a guardian by a court of an incapacitated person pursuant to 20 Pa. C.S.A. Section 5521.

1.36 **Maximum Age** means the point in time which a Family Dependent is no longer eligible for coverage as described in Section 6.2 and as set forth on the Schedule of Benefits.

1.37 **Maximum Out-of-Pocket** means the maximum dollar amount that a Member will be required to pay in a given Benefit Period for Covered Services, as set forth on the Schedule of Benefits. The Maximum Out-of-Pocket does not include the following:

(i) amounts above a specific Benefit Limit as set forth in the Certificate and/or Schedule of Benefits;

(ii) amounts above the PPO's Non-Preferred Provider Fee Schedule Amount; and
(iii) amounts for non-Covered Services.

This means that the Subscriber or the Member, not the PPO, will be responsible for payment of all the amounts noted above, even if the Maximum Out-of-Pocket has been reached. **As item (ii) can result in substantial financial responsibility for the Subscriber or Member,**

please refer to Exhibit 2 of this Certificate for an illustration of potential Cost Sharing when Non-Preferred Providers are utilized.

Please note there are separate Maximum Out-of-Pocket amounts for Preferred and Non-Preferred Providers. Maximum Out-of-Pocket amounts paid for Covered Services provided by either a Preferred Provider or a Non-Preferred Provider do not accrue towards each other. The Maximum Out-of-Pocket applies to each Covered Person or Family Unit subject to any family Maximum Out-of-Pocket set forth on the Schedule of Benefits.

1.38 **Medical Director** means the licensed physician designated by the PPO to direct the medical and scientific aspects of the PPO, and to oversee the quality and appropriateness of the managed health services.

1.39 **Medical Necessity or Medically Necessary** means Covered Services rendered by a Health Care Provider that the PPO determines are:

a) appropriate for the symptoms and diagnosis and treatment of the Member's condition, illness, disease or injury;

b) provided for the diagnosis, and the direct care and treatment of the Member's condition, illness, disease or injury;

c) in accordance with current standards of good medical treatment practiced by the general medical community;

d) not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

1.40 **Medicare** means the programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

1.41 **Member** means an individual eligible to receive Covered Services or benefits under the terms of this Certificate either as the Subscriber or an individual who is:

1) a newborn child, whether natural born, adopted, or placed for adoption, for thirty-one (31) days from the date of birth; and/or

2) an eligible enrolled Family Dependent, (except as defined under Sections 5, to include a Member's representative and Section 8 for Coordination of Benefit purposes).

1.42 **Mini-COBRA** means the continuation coverage, as may be amended from time to time, enacted by the Commonwealth of Pennsylvania for Members in a Mini-COBRA eligible Group of two (2) to nineteen (19) employees who incur certain qualifying events (as defined under Mini-COBRA).

1.43 **Network** means the Health Care Providers who have entered into a written agreement with the PPO to provide Covered Services to Members as part of the PPO's panel of Preferred Providers.

1.44 **Non-Preferred Provider** means a Health Care Provider or Provider that does not have an agreement with the PPO to provide Covered Services to the PPO's Members and is not part of the PPO's Network.

1.45 **Non-Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Non-Preferred Provider which is generally a percentage of Medicare reimbursement. The Member may obtain the Non-Preferred Provider Fee Schedule Amount by contacting the Customer Service Team at the number set forth on the Identification Card.

1.46 **Open Enrollment Period** means those periods of time established by the Group and the PPO from time to time, during which eligible persons may enroll.

1.47 **Orthotic Device** means a rigid appliance or apparatus used to support, align or correct bone and muscle deformities.

1.48 **Precertification** means the process detailed in Section 2.3.1 of this Certificate whereby all non-emergency inpatient hospital admissions or certain designated procedures and services as listed in Exhibit 3, Precertification List, of this Certificate are reviewed by the PPO for coverage determination based on Medical Necessity prior to the provision of services.

1.49 **Preferred Facility Provider** means a hospital, facility or institution licensed, certified or otherwise regulated under the laws of the Commonwealth of Pennsylvania, or another state, as applicable, that has an agreement with the PPO to provide Covered Services to Members as a Preferred Provider.

1.50 **Preferred Provider or Preferred Health Care Provider** means a Health Care Provider that has an agreement with the PPO pursuant to which negotiated rates are established on a Preferred Provider basis for payment of Covered Services to Members under this Certificate and pursuant to which such Health Care Provider is a part of the PPO's Network. The PPO contracts with a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Preferred Providers.

1.51 **Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Preferred Provider based on the contractual arrangement between the PPO and the Preferred Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Member.

1.52 **Preferred Provider Organization (PPO)** means Geisinger Quality Options, Inc.

1.53 **Primary Care Services** means initial and basic medical health care services provided by a general or family care practitioner, internist or pediatrician.

1.54 **Prosthetic Device** means an appliance or apparatus which replaces a missing body part.

1.55 **Provider** means Health Care Provider.

1.56 **Provider List** means a published listing (as amended from time to time) provided to Members by the PPO which sets forth the names, addresses and telephone numbers of current Preferred Providers who have contracted with the PPO to provide Covered Services. The current Provider List can be found on the PPO's website (at www.thehealthplan.com). A Member may also request a copy of the most current Provider List by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card or by writing to the Customer Service Team at the address listed on page (iii) of this Certificate.

1.57 **Rider** means a document that describes the terms and conditions applicable to specific Supplemental Health Services purchased by the Group to be in effect for the Subscriber and all Family Dependents enrolled under this Certificate. All Riders in force under this Certificate are listed on the current Schedule of Benefits.

1.58 **Schedule of Benefits** is a summary of coverage for a Member that identifies the Maximum Age for dependent coverage together with the applicable Deductible, Copayments, Coinsurance, Maximum Out-of-Pocket amounts, Benefit Limits and amounts for Covered Services, and any Riders in force for the Certificate. If there is a change in any of the information printed on the Schedule of Benefits (for example, an item has been printed incorrectly or the wrong Schedule of Benefits has been provided), the PPO will issue a new Schedule of Benefits to replace all prior Schedules of Benefits.

1.59 **Service Area** means the Pennsylvania counties listed in Exhibit 1, as amended from time to time, for which the PPO is licensed to operate by the Pennsylvania Department of Health.

1.60 **Specialist** means a Provider whose practice is not limited to Primary Care Services and who has additional post graduate or specialized training, board certification or practices in a licensed specialized area of health care.

1.61 **Subscriber** means an individual who meets the requirements for eligibility, who has enrolled in the PPO, and for whom payment has actually been received by the PPO. A Subscriber is also a Member.

1.62 **Substance Abuse** means any use of drugs and/or alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

1.63 **Supplemental Health Services** are those benefits provided under the Riders listed on the Schedule of Benefits.

1.64 **Tel-A-Nurse** is the twenty-four (24) hour a day access to nurse advice available to Members by the toll free number set forth on the Member Identification Card or by "live chat" on the PPO's website at www.thehealthplan.com. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.

1.65 **Urgent Care** means any Covered Service provided to a Member in a situation which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency Service as it allows the Member to consider alternative settings of care. If the Member is out of the Service Area and needs Urgent Care, to be covered, the care must be in response to a sudden and unexpected condition or injury that needs care which cannot be put off until the Member returns to the Service Area.

SECTION 2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS

2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS.

2.1 Medical Management Procedures. The following is a description of the PPO's medical management procedures.

a) Non-emergency inpatient admissions and certain designated services and procedures identified in this Section received from Non-Preferred Providers or Preferred Providers **REQUIRE** Precertification by the PPO as set forth in this Section.

b) The PPO clinical staff is available to assist Members who require transplants, have catastrophic disease or injury, are temporarily outside the Service Area and require Urgent Care, or can benefit from individualized attention to coordinate their needs.

c) The PPO medical management staff coordinates with the quality improvement staff to collect data and review issues to assure appropriate care in the most efficient manner.

d) Concurrent review (a review of the Member's care while under an ongoing course of treatment) may be required for services such as, but not limited to, inpatient admissions (including emergencies and admissions where the PPO is not the primary payor), home health care and outpatient rehabilitation. Concurrent review is the responsibility of the facility, not the Member.

e) A PPO Medical Director will be involved in any decision to deny coverage on the basis of Medical Necessity.

f) Covered Services are approved based on qualities or attributes which are determined by the PPO to be: (i) Medically Necessary; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available.

The PPO's medical management policies and procedures comply with all National Committee for Quality Assurance standards (if such standards are applicable) and all applicable state and federal regulations regarding medical management and utilization**.**

2.2 Precertification. The purpose of Precertification is to determine Medical Necessity and to encourage and facilitate use of the most appropriate level of care for Medically Necessary services utilizing objective and evidence based criteria taking individual circumstances and the local delivery system into account. In the absence of criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations. Alternate treatment settings may be recommended for approved procedures if inpatient hospitalization is deemed unnecessary. Precertification does not verify a Covered Person's coverage by the PPO or guarantee payment. Precertification is required even when the PPO is not the primary carrier.

2.3 Designated Procedures and Services Requiring Precertification. All non-emergency inpatient hospital admissions as well as the designated procedures and services listed below **REQUIRE** Precertification. Precertification is required for such services regardless of whether they are performed in an inpatient or outpatient setting.

Please refer to **Exhibit 3** of this Certificate for a list of services, supplies, agents/medications which require Precertification.

2.3.1 **Precertification Process.** The Precertification process begins when a non-emergency inpatient hospital admission or designated procedure or service identified in this Section is proposed.

a) If the Member chooses to utilize a **Preferred Provider** for an inpatient hospital admission or the procedures or services indicated in this Section, ***such Preferred Provider*** is responsible for obtaining Precertification from the PPO before the inpatient hospital admission or designated procedure or service occurs. In the event the Preferred Provider fails to obtain Precertification as required, the Member will not be held financially accountable for such services.

b) If the Member chooses to utilize a **Non-Preferred Provider**, the ***Member*** is responsible for (i) informing the Non-Preferred Provider that Precertification is required prior to receiving the procedure or service and (ii) ensuring that Precertification is obtained from the PPO prior to receiving the procedure or service. The Member may do this by contacting the Customer Service Team at the telephone number listed on the back of the Member's Identification Card.

c) Both the Preferred Provider and the Non-Preferred Provider, as applicable, will need to provide the PPO with medical information. A decision regarding coverage of proposed services will be made within the time frames required by applicable law.

d) Written notification of approval or denial of the proposed services will be provided to (i) the Member and the Preferred Provider or (ii) the Member and the Non-Preferred Provider, as applicable, within the time frames required by applicable law. **PLEASE NOTE THAT THE PRECERTIFICATION PROCESS HAS NOT BEEN COMPLETED IF A NOTIFICATION LETTER HAS NOT BEEN RECEIVED BY THE MEMBER.**

Members dissatisfied with the results of the Precertification process may use the established appeal procedure set forth in Section 5 of this Certificate. Members and Providers will receive detailed instructions regarding the appeal process as an attachment to the notification letter, as appropriate.

2.3.2 **Ultimate Responsibility for Precertification When the Member Chooses to Utilize a Non-Preferred Provider.** Although a Non-Preferred Provider may contact the PPO for Precertification on the Member's behalf, **it is ultimately the responsibility of the Member to ensure that Precertification occurs prior to the date of service when the Member chooses a Non-Preferred Provider for the services and procedures set forth in this Section.**

2.3.3 **Failure to Precertify**. All services and procedures identified in this Section which are rendered by a Non-Preferred Provider and which **REQUIRE** Precertification are **NOT COVERED** when Precertification is not obtained.

SECTION 3. COVERED SERVICES

Subject to the exclusions, conditions and limitations of this Certificate, a Member is entitled to benefits for Covered Services when (i) deemed to be Medically Necessary and (ii) billed for by a Provider. Payment allowances for Covered Services are set forth on the Schedule of Benefits and in accordance with the procedures set forth in Section 2 of the Certificate. The fact that a Provider prescribed, ordered, recommended or approved a medical service or supply does not automatically constitute coverage by the PPO.

Please be advised that the benefits set forth in this Section 3 are subject to the Copayments, Coinsurance, Deductibles, Maximum Out-of-Pocket and Benefit Limits that are specifically set forth on the Schedule of Benefits as well as the individual Benefit Limits set forth in this Section 3 and on the Schedule of Benefits. Preventive Services as set forth in Section 3.26 and Exhibit 4 of this Certificate or as set forth on the Schedule of Benefits are not subject to any Deductible.

HOW A COVERED SERVICE MAY BE OBTAINED, COVERAGE LIMITS AND MEMBER'S COST SHARING OBLIGATIONS:

3.1 The following Sections set forth how a Member may obtain services from a Non-Preferred Provider without incurring Non-Preferred Provider Cost Sharing (Section 3.1.1), coverage parameters regarding Covered Services (Sections 3.1.2.), Covered Service location Cost Sharing (Section 3.1.3), and Supplemental Health Services (Section 3.1.4).

The Member is encouraged to call the Customer Service Team at the telephone number on the back of the Member's Identification Card if there are questions relating to the Covered Services set forth in this Section, Cost Sharing or how the Covered Service may be obtained by the Member.

3.1.1 **Covered Services from a Non-Preferred Provider.** The following are exceptions where Covered Services may be obtained from a Non-Preferred Provider without incurring Non-Preferred Provider Cost Sharing:

a) Emergency Services as set forth in Section 3.9 of this Certificate;

b) Urgent Care as set forth in detail in Section 3.35 of this Certificate;

c) when Covered Services are not available from a Preferred Provider; or

d) for Covered Services under this Certificate in accordance with the continuation of benefits provisions set forth in Section 8.9.

3.1.2 **The PPO's Coverage of Covered Services**:

3.1.2.1 **Coverage**. The fact that the Member's Provider may prescribe, order, recommend or approve a medical service or supply does not automatically constitute coverage by the PPO. Only health care services expressly subject to the terms and conditions set forth in this Section of the Certificate, Amendments to this Certificate and any attached Riders will be covered.

3.1.2.2 **Covered Services Obtained Outside the Service Area.** Covered Services required as a result of circumstances that reasonably could have been foreseen prior to the Member's departure from the Service Area and Covered Services which can be delayed until the Member's return to the Service Area are covered at the Non-Preferred Provider rate.

3.1.2.3 **Maternity care outside the Service Area**. Maternity care for normal term delivery if received outside the Service Area will not be covered at the Preferred Provider rate if rendered by a Non-Preferred Provider. Treatment of unexpected complications of pregnancy and care for unexpected early delivery are covered as Emergency Services.

3.1.3 **Covered Service Location Cost Sharing**. Certain benefits (as indicated on the Member's Schedule of Benefits) will subject the Member to a Copayment based on the type of facility where the Covered Service is provided. This Copayment is in addition to any Cost Sharing obligation for the Covered Service being provided to the Member.

3.1.4 **Supplemental Health Services as set forth in Rider(s)**. The Member's Schedule of Benefits will list any Rider(s) supplementing this Certificate as well as the Member's Cost Sharing obligations related to the Rider(s). Members should note that the conditions listed above in Sections 3.1.1, 3.1.2 and 3.1.3 will also apply to the Supplemental Health Service Benefits set forth in the Rider(s). The terms and conditions of each Rider will detail how these Sections apply to the Supplemental Health Services provided by the Rider. If a Rider is listed as an exception to a Benefit in this Section 3, the Member should pay particular attention to the terms of that Rider (if in force with their Certificate) as the benefit will differ from that listed in this Section.

IDENTIFICATION OF COVERED SERVICES

Subject to all terms, conditions, definitions, exclusions and limitations in this Certificate, Members are entitled to receive the following Covered Services as set forth in this Section. All Covered Services must be Medically Necessary except for **Preventive Services** as set forth in Section 3.26 and Exhibit 4 of this Certificate.

3.2 Autism Spectrum Disorder Covered Services.

DEFINITIONS. For the purpose of this Section, the following definitions shall apply:

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

Autism Spectrum Disorder means any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Autism Spectrum Disorder Provider means a Pennsylvania licensed or certified person, entity or group providing Treatment of Autism Spectrum Disorders pursuant to a Treatment Plan.

Mandated Benefits means any additional Covered Services as required by state or Federal law in effect for the Subscriber and all Family Dependents enrolled under the Certificate.

Preferred Pharmacy means a pharmacy which has in effect on the date of service, an agreement with the PPO to provide prescription drugs to Members and is so designated by the PPO. For pharmacies that are not in the PPO's Service Area, prescription drugs or refills may be filled at Preferred Pharmacies.

Treatment of Autism Spectrum Disorders shall be identified in a Treatment Plan and shall include any Medically Necessary Pharmacy Care Services, Psychiatric Care Services, Psychological Care Services, Rehabilitative Care Services and Therapeutic Care Services that are:

a) prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner;

b) provided by an Autism Spectrum Disorder Provider;

c) provided by a person, entity or group that works under the direction of an Autism Spectrum Disorder Provider.

Treatment Plan means a plan for the Treatment of Autism Spectrum Disorders which is developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The PPO may review a Treatment Plan for Treatment of an Autism Spectrum Disorder once every six (6) months subject to its utilization review requirements. A more or less frequent review can be agreed upon by the PPO and the licensed physician or licensed psychologist developing the Treatment PPO.

BENEFITS.

3.2.1 **Autism Spectrum Disorder Services.** Coverage for Autism Spectrum Disorder Services is provided to Members under age twenty-one (21) years of age for the diagnostic assessment of Autism Spectrum Disorders and for the Treatment of Autism Spectrum Disorders when provided by an Autism Spectrum Disorder Provider. Such assessment and treatment may include the following Medically Necessary services consistent with the specific requirements set forth below.

3.2.1.1 **Pharmacy Care Services.** Pharmacy Care Services include medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. Prescriptions for prescribed medications must be obtained from a Preferred Pharmacy.

3.2.1.1.1 **Cost Sharing.** Pharmacy Care Services Cost Sharing shall be as set forth in Section 3.24, **Outpatient Prescription Drugs**.

3.2.1.2 **Psychiatric Care Services.** Psychiatric Care Services include direct or consultative services provided by a physician Autism Spectrum Disorder Provider who specializes in psychiatry.

3.2.1.2.1 **Cost Sharing.** Psychiatric Care Services Cost Sharing shall be the Copayment set forth on the Schedule of Benefits, listed under "Mental Health Services" as the "Outpatient Professional Services" Copayment.

3.2.1.3 **Psychological Care Services.** Psychological Care Services include direct or consultative services provided by a psychologist Autism Spectrum Disorder Provider.

3.2.1.3.1 **Cost Sharing.** Psychological Care Services Cost Sharing shall be the Copayment set forth on the Schedule of Benefits, listed under "Mental Health Services" as the "Outpatient Professional Services" Copayment.

3.2.1.4 **Rehabilitative Care Services.** Rehabilitative Care Services include professional Autism Spectrum Disorder Provider services and treatment programs, including Applied Behavioral Analysis (see **NOTE** below), provided to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. Rehabilitative Care Services must be provided by an Autism Spectrum Disorder Provider.

3.2.1.4.1 **Cost Sharing**. Rehabilitative Care Services Cost Sharing for services received from a Preferred or Non-Preferred Provider shall be that set forth on the Schedule of Benefits, listed under "Physician Office Services" as the "Specialist Office Visit" Copayment.

3.2.1.5 **Therapeutic Care Services.** Therapeutic Care Services require Precertification by the PPO and include services provided by speech language pathologist, occupational therapist or physical therapist Autism Spectrum Disorder Providers.

3.2.1.5.1 **Cost Sharing**. Therapeutic Care Services Cost Sharing for services received from a Preferred or Non-Preferred Provider shall be that set forth on the Schedule of Benefits, listed under "Physician Office Services" as the "Specialist Office Visit" Copayment.

3.2.1.5.2 **Benefit Limits**. Physical, occupational and speech therapy is covered for up to thirty (30) visits per Benefit Period. This thirty (30) visit limit is for any combination of physical, occupational and speech therapy Covered Services received within the Benefit Period. Please note that this thirty (30) visit limit is shared with the Rehabilitation Services benefit set forth in Section 3.28.

3.2.2 **Expedited Review**. Upon the PPO's denial of a Member's claim for diagnostic assessment or Treatment of Autism Spectrum Disorder, a Member or a Member's Authorized Representative shall be entitled to the expedited internal review process consistent with the Expedited Review Procedure set forth in Section 5.4.2 of the Certificate and any subsequent independent external review process established and administered by the Pennsylvania Insurance Department. Any external review disapproving a denial or partial denial may be appealed to a court of competent jurisdiction.

Use of a Non-Preferred Autism Spectrum Disorder Provider or a Provider who does not participate in the Designated Behavioral Health Benefit Program will be subject to Out of Network Cost Sharing and may result in significant out-of-pocket expense for the Member.

3.3 Back Pain Management Program. The Back Pain Management Program ("Program") is a Covered Service provided to Members with spine/back pain. The Program is initiated when the Member seeks treatment from a Preferred Provider for spine/back pain. The Preferred Provider will evaluate the Member and develop a treatment plan based on the Member's clinical indications. Members meeting pre-determined medical criteria and requiring further evaluation will be referred to a Back Pain Management Specialist who will examine the Member and initiate a course of treatment for the Member which may include Back Pain Physical Therapy Rehabilitative Services as set forth below.

3.3.1 **Back Pain Physical Therapy Rehabilitative Services.** Upon Precertification, physical therapy rehabilitative services for spine/back pain ("Back Pain PT") are covered for up to thirty (30) visits per Benefit Period as set forth in Certificate Section 3.28, **Rehabilitative Services**.

3.3.2 Cost Sharing applicable to the first ten (10) Back Pain PT visits will be bundled into two (2) series of five (5) visits per series. Each series will count as five (5) visits toward the thirty (30) visit Benefit Limit described in Certificate Section 3.28, **Rehabilitative Services**. Cost Sharing applicable to each series is noted on the Schedule of Benefits.

3.4 Cardiac Rehabilitation. Outpatient cardiac rehabilitation is covered for up to thirty-six (36) visits per Benefit Period.

3.5 Diabetic Medical Equipment, Supplies, Prescription Drugs and Services. The following diabetic medical equipment, supplies, prescription drugs and services for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are covered if prescribed by a health care professional legally authorized to prescribe such items under law when provided by a Preferred Provider. The PPO reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.

3.5.1 **Diabetic Medical Equipment.** The PPO will cover standard diabetic medical equipment including insulin infusion devices, blood glucose monitors, insulin pumps and injection aids. Injection aids shall include needle-free injection devices, bent needle set for insulin pump infusion and non-needle cannula for insulin infusion.

3.5.2 **Diabetic Foot Orthotics.** The PPO will cover diabetic foot orthotics only when provided by a Preferred Provider.

3.5.3 **Prescription Drugs.** The PPO will cover insulin and oral pharmacological agents for controlling blood sugar as prescribed by a Preferred Provider as well as disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips). Prescription drugs under this Section are subject to the prescription drug Cost Sharing as set forth in the Schedule of Benefits.

3.5.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered when provided under the supervision of a Preferred Provider with expertise in diabetes to ensure that Members with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. This shall include visits:

i) upon the diagnosis of diabetes;

ii) under circumstances whereby the Preferred Provider identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a Member's self-management; and

iii) where a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes has been identified as appropriate by the Preferred Provider.

3.5.4.1 **Cost Sharing.** Applicable Cost Sharing amounts for office visits and outpatient facility services may apply to this benefit and are specified on the Schedule of Benefits.

3.5.5 **Diabetic Eye Examinations**. The PPO will cover diabetic eye examinations when provided by a Preferred Provider. A Diabetic eye examination does not include a refraction of the eye(s).

3.6 Diagnostic Services. Diagnostic tests, services, and materials, including diagnostic radiology and imaging, laboratory tests and electrocardiograms are covered.

3.7 Disease Management Programs. The PPO offers programs focused on clinical health conditions including education and management. Participation in a PPO disease management/care management program may include coverage for certain services that would not otherwise be provided for under this Certificate.

3.8 Durable Medical Equipment (DME), Orthotic Devices and Prosthetic Devices.

3.8.1 **Definitions.** For the purposes of this **Durable Medical Equipment, Orthotic Devices and Prosthetic Devices** Section and Section 4.55 of **EXCLUSIONS**, the following definitions shall apply:

a) **Compliance or Compliant** means a Member's willingness to follow a prescribed course of treatment. Coverage of Durable Medical Equipment is contingent upon a Member's Compliance in using the equipment as indicated in the course of treatment as determined by the PPO.

b) **Deluxe Equipment** is equipment which has features that do not contribute significantly to the therapeutic function of the equipment, are only primarily beneficial in performing leisure or recreational activities or are essentially non-medical in nature.

c) **Related Supplies** means medical supplies which are required to support the use of covered Durable Medical Equipment.

d) **Rehabilitative Devices** are devices which meet the needs of individuals with disabilities and address the barriers confronted by such individuals. Rehabilitative Devices may address needs in the areas of education, rehabilitation, employment, transportation, and independent living. Rehabilitative Devices include only those devices or services required to overcome the functional limitations imposed by an individual's disability.

Examples of Rehabilitative Devices include but are not limited to a speaking board or other communication device for a Member who cannot speak and self-care/home management training such as ADL (Activities of Daily Living) and compensatory training/instructions in the use of adaptive equipment.

Rehabilitative Devices do not include:

i) Devices or services which are considered restoration devices or services. Restoration devices and services are those available under a prescription from a qualified Health Care Provider and/or are available through Medicaid or third party medical insurance (examples include but are not limited to prosthetic and orthotic devices, wheelchairs and hearing aids).

ii) Devices or services which are considered equipment. Equipment devices or services are those required solely for training or employment and are not required as a result of the individual's disability.

3.8.2 **Durable Medical Equipment (DME) and Related Supplies.** Upon Precertification by the PPO, the PPO will cover the cost of renting, or at its option, purchasing Medically Necessary DME and Related Supplies when prescribed in advance by a Preferred Provider for use consistent with required Food and Drug Administration (FDA) approved labeling for the item. This benefit includes the cost of delivery and installation. Repair and replacement of DME is covered only to the extent required as a result of normal wear and tear. DME must be obtained from a Preferred Provider. The PPO reserves the right to recover any DME purchased by the PPO when such device or piece of equipment is no longer Medically Necessary or in the event that the Member is not Compliant in utilization of the equipment as indicated in the course of treatment and determined by the PPO. Coverage of DME is subject to the Exclusions set forth in Section 4.55 of this Certificate.

3.8.2.1 **Durable Medical Equipment Vendors**. The PPO reserves the right to restrict the selection of vendors for DME covered under this Certificate.

3.8.2.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Durable Medical Equipment covered under this Certificate. Such restriction is subject to change by the PPO without the consent or concurrence of the Member except as provided for herein.

3.8.3 **Orthotic Devices**. The PPO will pay for the purchase of Orthotic Devices when prescribed in advance by a Preferred Provider or when approved in advance by

the PPO. Orthotic Devices must be obtained from a Preferred Provider unless authorized in advance by the PPO. Coverage of Orthotic Devices is subject to the Exclusions set forth in Section 4.55 of this Certificate.

3.8.4 **Prosthetic Devices**. The PPO will pay for the purchase of one (1) Prosthetic Devices, or the replacement of component parts or modification of a Prosthetic Device every five (5) years when obtained from a Preferred Provider subject to the Exclusions set forth in Section 4.55.21 of this Certificate. However, the initial and subsequent Prosthetic Devices following a mastectomy to replace the removed breast or portions thereof are not subject to the five (5) year Benefit Limit set forth above.

3.8.4.1 **Members under Age Nineteen (19)**. For a Member who is under the age of nineteen (19) years, this benefit includes the replacement of component parts or modification of a Prosthetic Device occasioned by the Member's growth, in addition to the initial purchase of such a device.

3.8.4.2 **Manufacturer**. The PPO reserves the right to restrict the manufacturer of Prosthetic Devices covered under this Certificate. Such restriction is subject to change by the PPO without the consent or concurrence of the Member, except as provided for herein.

3.9 Emergency Services. Emergency Services do not require Precertification by the PPO. Coverage for Emergency Services provided during the period of the emergency shall include evaluation, testing, and if necessary, stabilization of the condition of the Member. The use of emergency transportation and related Emergency Services provided by a licensed ambulance service shall be covered as an Emergency Service subject to the limitations in this Section. If a Member requires Emergency Services and cannot be attended to by a Preferred Provider, the PPO shall cover the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Preferred Provider, subject to Sections 3.9.1(d) and 3.9.2 below.

3.9.1 **Emergency Services Protocol.**

a) When an emergency happens, the Member should call 911 or an emergency information center in his area, or safely proceed immediately to the nearest Emergency Services Health Care Provider.

b) If a Member requires hospitalization following an emergency, the Emergency Services Health Care Provider is responsible to notify the PPO within forty-eight (48) hours, or on the next business day, whichever is later, of the Emergency Services rendered to the Member.

c) If the Member is not admitted to a hospital or other health care facility, the claim for reimbursement for Emergency Services provided shall serve as notice to the PPO of the Emergency Services provided by the Emergency Services Health Care Provider.

d) Medically Necessary follow-up services after the initial response to an emergency are not Emergency Services.

e) Medically Necessary follow-up services obtained from a Non-Preferred Provider after the initial response to an emergency are not Emergency Services.

f) For the emergency treatment of sound, natural teeth please refer to Section 3.22.2, Oral Surgery**.** The need for these services must result from an accidental injury (not chewing or biting).

3.9.2 **Non-Preferred Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Preferred Provider, the PPO shall pay for the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Preferred Provider. However, Emergency Services provided by Non-Preferred Providers will be covered as if provided by a Preferred Provider only until the PPO determines the Member's condition has stabilized and the Member can be transported to a Preferred Provider without suffering detrimental consequences or aggravating the Member's condition. The Member may continue to use the Non-Preferred Provider at the Non-Preferred Provider rates.

3.9.3 **Cost Sharing.** Emergency Services are subject to the Cost Sharing amounts specified on the Schedule of Benefits. The Cost Sharing will be waived if Emergency Services rendered in the emergency department of an acute care hospital result in the immediate admission of the Member to the hospital as an inpatient and the requirements for Emergency Services set forth in Section 1.21 of the Certificate and this Section 3.9 are satisfied.

3.10 Enteral Feeding/Food Supplements. The cost of outpatient enteral tube feedings including administration, supplies and formula used as food supplements is covered for nutritional supplements for the therapeutic treatment of aminoacidopathic hereditary metabolic disorders (phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria) when administered under the direction of a physician Preferred Provider. Upon Precertification, coverage consideration may also be given when enteral or parenteral feeding is the sole source of nutrition.

3.11 General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care.

3.11.1 **Definition of General Anesthesia**. For the purpose of this Section, General Anesthesia is defined as: a controlled state of unconsciousness, including deep sedation, that is produced by a pharmacologic method, a non-pharmacologic method or a combination of both and that is accompanied by a complete or partial loss of protective reflexes that include the patient's inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

3.11.2 **Definition of Associated Medical Costs**. For the purpose of this Section, Associated Medical Costs is defined as: hospitalization and all related medical expenses normally incurred as a result of the administration of General Anesthesia.

3.11.3 **Covered Services.** Upon Precertification, General Anesthesia and related professional services provided in connection with inpatient or outpatient dental care or an oral surgery procedure and Associated Medical Costs are covered only if such services are Medically Necessary and are required because the Member:

a) has an existing medical condition unrelated to the dental or oral surgical procedure; or

b) has a medical condition that precludes the use of local anesthetic or in which local anesthetic is ineffective; or

c) is a child age seven (7) or younger; or

d) is developmentally disabled and for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under General Anesthesia.

Such General Anesthesia must be provided by a Preferred Provider in a hospital or Ambulatory Surgical Center.

3.12 Habilitative Services. Habilitative services are Medically Necessary services that help a person gain, keep, or improve skills for daily living. Such services may include physical and occupational therapy, speech-language pathology, autism spectrum disorder services and other services as may be determined by a Provider or the PPO. Habilitative Services are subject to the Cost Sharing and applicable Benefit Limits as set forth on the Schedule of Benefits for the specific service provided.

3.13 Home Health Care. Upon Precertification by the PPO, home health care is covered only in the event a Member is homebound except as provided in Section 3.13.4 of this Certificate. A Member shall be considered homebound when the medical condition of the Member prohibits the Member from leaving home without extraordinary effort, unless the absences from home are attributable to the Member's need to receive medical treatment which cannot be reasonably provided in the home such as physician appointments, diagnostic or therapeutic procedures. This Section does not apply to home health care services for follow-up maternity care for early discharge which is set forth at Section 3.19 of this Certificate.

If the Member has an approved treatment plan established by a home health agency Provider and a physician Provider, then the following home health care services are covered:

3.13.1 **Skilled Nursing Personnel.** Skilled nursing visits in the home that are provided by skilled nursing personnel who are supervised by physician Providers, are covered upon Precertification by the PPO in accordance with Section 2 of this Certificate.

3.13.2 **Physician Services.** When the nature of the illness dictates, care in the home by a physician is covered. Precertification is required in accordance with Section 2 of this Certificate.

3.13.3 **Other Health Care Personnel.** Medical care in the home is covered when the care is given by Health Care Providers (including but not limited to, speech, physical and occupational therapists) under the supervision of a physician Provider. This care is covered upon Precertification by the PPO, subject to any specific benefit limitations set forth in this Section 3 of the Certificate.

3.13.4 **Follow-Up Care Post-Mastectomy Surgery.** One (1) home health visit after discharge of mastectomy surgery is covered provided that the discharge occurs within forty-eight (48) hours of admission for mastectomy surgery whether or not the Member is homebound.

3.14 Hospice. The following services for Hospice are covered: Routine Home Care, Continuous Care, General Inpatient Care, and Respite Care, as well as those Hospice services noted in this Certificate, provided such care is:

a) has received Precertification by the PPO; and

b) is directly related to the Terminal Illness of a Member and rendered in accordance with the Member's Plan of Care.

3.14.1 **Hospice Benefit Election.** The Member shall have the option to elect to receive Hospice benefits as set forth in this Certificate. By electing to receive the Hospice benefit, the Member acknowledges that he or she:

a) shall not receive curative care but rather palliative care solely for reducing the intensity of and management of the Member's Terminal Illness;

b) waives the right to the PPO standard benefits for treatment of the Terminal Illness and related conditions; and

c) retains all normal coverage, as set forth in the Member's Certificate, for Covered Services not related to the Terminal Illness.

3.15 Hospital and Ambulatory Surgical Center Services.

3.15.1 **Benefits.** Hospital benefits may be provided at a hospital Provider on either an inpatient or outpatient basis or at an Ambulatory Surgical Center. Hospital services include semi-private room and board (private room when determined Medically Necessary by the PPO), general nursing care and the following additional facilities, services and supplies as prescribed by a physician Provider: use of operating room and related facilities; use of intensive care unit or cardiac care unit and services; radiology, laboratory, and other diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; physical therapy, occupational therapy and speech therapy (subject to the Benefit Limits set forth in Section 3.28 of this Certificate and on the Schedule of Benefits); radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma and medical social services; cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

3.15.2 **Precertification.** All non-emergency inpatient hospital admissions require Precertification as detailed in Section 2.3.1 of this Certificate.

3.15.3 **Duration of the Benefit.** Inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the PPO and not determined to be Custodial, Convalescent or Domiciliary Care, except for mastectomy Covered Services as set forth in Section 3.18 of this Certificate. In addition, the number of inpatient days when utilizing a Non-Preferred Provider is specified on the Schedule of Benefits.

3.16 Implanted Devices. The following implanted devices are covered when provided by a Provider and when the implanted devices are within the Provider's scope of practice: implanted devices for purposes of drug delivery; cardiac assistive devices; cochlear implants

and artificial joints. These devices are only covered to correct dysfunction due solely to disease or injury and not for gender reassignment.

3.16.1 **Cost Sharing.** Implanted devices for purposes of drug delivery are covered subject to the implanted device Cost Sharing amounts specified on the Schedule of Benefits. Implanted devices not for purposes of drug delivery (such as cardiac assistive devices, cochlear implants and artificial joints) are covered subject to the Cost Sharing amounts specified on the Schedule of Benefits.

3.17 Manipulative Treatment Services. Manipulative Treatment Services are covered for twenty (20) visits per Benefit Period at the Cost Sharing set forth on the Schedule of Benefits. Manipulative Treatment Services must be provided by a Preferred Provider qualified to perform these services.

3.17.1 **Covered Services**. Manipulative Treatment Services covered under this Certificate are limited to spinal Manipulative Treatments.

3.17.2 **Benefit Limit.** Manipulative Treatment Services provided under this Certificate shall be limited to twenty (20) visits each Benefit Period. Members must pay for any Manipulative Treatment Services received above this Benefit Limit.

3.18 Mastectomy and Breast Cancer Reconstructive Surgery. Covered Services for Members who elect breast reconstructive surgery in connection with a Medically Necessary mastectomy will include:

a) reconstruction of the breast on which the mastectomy was performed; and

b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c) initial and subsequent Prosthetic Devices to replace the removed breast or portions thereof following a mastectomy will be provided; and

d) treatment of physical complications at all stages of the mastectomy including lymphedemas.

The attending Provider, in consultation with the Member, will determine the manner in which Covered Services are to be provided.

3.19 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the Provider. Certified licensed nurse midwife Provider services shall be covered only if obtained

from a Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.21 of this Certificate.

3.19.1 **Cost Sharing.** Each covered day of a hospital stay and related physician for maternity are subject to the inpatient hospital Cost Sharing specified on the Schedule of Benefits. A postpartum home health care visit within forty-eight (48) hours for an early discharge is not subject to any Copayment, Deductible or Coinsurance amounts under this Section.

3.19.2 **Childbirth Preparedness Classes.** Childbirth preparedness classes for education focused on preparing for labor and the birth of a child are covered for pregnant female Members up to a $100 limit per Benefit Period. Such classes are intended to prepare female Members for childbirth and may not be related solely to child rearing. Classes may be provided by a Preferred or Non-Preferred Provider. In order to be reimbursed by the PPO for a childbirth preparedness class, the Member must follow the requirements of Section 8.14, of the Certificate. However, the Member is **not required** to follow the claim form requirements set forth in Section 8.14.1 of the Certificate; instead, the Member should submit a copy of the childbirth preparedness class receipt indicating the payment amount and the completion date of the class.

3.20 **Mental Health Services**. The following services are covered when obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional:

3.20.1 **DEFINITIONS.** For the purpose of this Section, the following definitions shall apply:

3.20.1.1 **Non-Serious Mental Illness** means any mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual excluding: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

3.20.1.2 **Serious Mental Illness** means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

3.20.2 **Serious Mental Health Inpatient Services.** The cost of inpatient services for the treatment of Serious Mental Illness, provided in a mental hospital or psychiatric unit of an acute hospital, (including the cost of services provided by a psychiatrist, licensed clinical psychologist, or other licensed behavioral health professional), is covered upon Precertification. Mental Health Inpatient Services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Mental Health Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

3.20.2.1 **Partial Hospitalization**. The cost of partial hospitalization services for the treatment of Serious Mental Illness provided through a partial hospitalization program is covered. Partial hospitalization services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits. Partial hospitalization services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to Precertification and are subject to the Non-Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing set forth on the Schedule of Benefits.

3.20.3 **Serious Mental Illness Outpatient Professional Mental Health Services.** The cost of outpatient professional services for the treatment of Serious Mental Illness provided by or under the direction of psychiatrists, licensed clinical psychologists, or other behavioral health professionals is covered upon Precertification for either individual or group therapy (combined) per Benefit Period. Outpatient Professional Mental Health Services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Outpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Mental Health Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Outpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

3.20.3.1 **Partial Hospitalization**. The cost of partial hospitalization services for the treatment of Serious Mental Illness provided through a partial hospitalization program is covered. Partial hospitalization services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits. Partial hospitalization services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to Precertification and are subject to the Non-Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing set forth on the Schedule of Benefits.

3.20.4 **Non-Serious Mental Health Inpatient Services**. The cost of inpatient services for the treatment of Non-Serious Mental Illness, provided in a mental hospital or psychiatric unit of an acute hospital, (including the cost of services provided by a psychiatrist, licensed clinical psychologist or other licensed behavioral health professional) is covered. Non-Serious Mental Health Inpatient Services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Non-Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Non-Serious Mental Health Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to Precertification and are subject to the Non-Preferred Provider "Non-Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

3.20.4.1 **Partial Hospitalization**. The cost of partial hospitalization services for the treatment of Non-Serious Mental Illness provided through a partial hospitalization program is covered. Non-Serious Mental Health partial hospitalization services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Non-Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits. Non-Serious Mental Health partial hospitalization services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to Precertification and are subject to the Non-Preferred Provider "Non-Serious Mental Illness Partial hospital Services" Cost Sharing set forth on the Schedule of Benefits.

*** NOTE: The use of a Non-Preferred Provider under this Section 3.20 rather than a Provider who participates in the Designated Behavioral Health Benefit Program may subject the Member to significant out-of-pocket expense**.

3.21 Newborn Coverage. Newborn children are covered as Members from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary care for the treatment of medically diagnosed congenital defects and birth abnormalities (as also set forth in Section 3.29.1 of this Certificate); prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Section 6.2.2.

3.22 Oral Surgery. The following limited oral surgical services are covered:

3.22.1 **Non-dental Treatment of the Mouth** relating to medically diagnosed congenital defects, birth abnormalities, or excision of tumors.

3.22.2 **Services and Supplies Necessary for the Emergency Treatment of Sound, Natural Teeth.** The need for these services must result from an accidental injury (not chewing or biting).

3.22.3 **Temporomandibular Joint (TMJ) Surgery** is limited to the following:

a) correction of dislocation or complete degeneration of the temporomandibular Joint (TMJ);
b) consultations to determine the need for surgery; and/or
c) radiologic determinations of pathology.

3.22.4 **Hospital and Ambulatory Surgical Center Services and Related Professional Services** provided in connection with a dental or oral surgery procedure provided on an inpatient or outpatient basis, only if the hospital or Ambulatory Surgical Center services are required for an existing medical condition unrelated to the dental or oral surgical procedure. Such coverage requires Precertification by the PPO.

3.23 Ostomy Supplies. The PPO will cover ostomy supplies provided by a Preferred Provider only for Members who have had a surgical procedure which resulted in the creation of a stoma (an artificial opening in the body which remains after the surgery is completed).

3.24 Outpatient Prescription Drugs. Formulary Prescription Drugs and Mail Order Prescription Drugs prescribed for a Member are covered when provided by a Preferred Pharmacy or

Preferred Mail Order Pharmacy as applicable. Restricted drugs or certain drugs requiring Prior Authorization or Precertification prescribed for a Member are covered only upon Prior Authorization or Precertification by the PPO and when provided by a Preferred Pharmacy or Preferred Mail Order Pharmacy. Outpatient Prescription Drugs are subject to the **EXCLUSIONS** as set forth in Section 4.56 of this Certificate.

3.24.1 **Definitions**. For the purpose of this Section 3.24 and Section 4.56 of **EXCLUSIONS**, the following definitions are applicable:

b) **Brand Name Drug** as used in this Certificate means a medication for which there is not an AB-rated Generic equivalent available or the non-Generic form of a medication when a Generic is available.

c) **Drug Formulary or Formulary** means a continually updated list of prescription medications that represents the current covered drugs by the PPO based upon the clinical judgment of the PPO's Pharmacy and Therapeutics Committee. The Drug Formulary contains both Brand Name Drugs and Generic Drugs, all of which have been approved by the U.S. Food and Drug Administration (FDA). A current list of drugs included on the Drug Formulary is provided when the Member becomes covered under the Certificate. Subsequent updates to the Formulary may be obtained by contacting the PPO at the telephone number on the back of the Member's Identification Card or can be viewed on the PPO's Web site at www.thehealthplan.com.

d) **Formulary Brand Name Drug** means a Brand Name Drug which is included in the PPO's Drug Formulary.

e) **Generic Drug or Generic** means a Prescription Drug that is (i) permitted under applicable law; (ii) so designated as a chemical equivalent product substitution and set forth in the manual published by the United States Department of Health and Human Services entitled, "Approved Drug Products with Therapeutic Equivalence Evaluations" (the "Orange Book"); or (iii) designated as a Generic by another third party, selected at the PPO's sole discretion, such as the First Data Bank; and (iv) approved by the PPO.

f) **Mail Order Prescription Drug** means any Maintenance Prescription filled through the PPO's Mail Order Prescription Drug Program.

f) **Maintenance Prescription Drug** means any Prescription Drug that is available through the Preferred Mail Order Pharmacy as defined by the PPO and that would be taken on an ongoing basis to treat a chronic condition.

g) **Non-Formulary Brand Name Drug** as used in this Certificate means a Brand Name Drug not listed in the PPO's Drug Formulary.

h) **Preferred Mail Order Pharmacy** means a pharmacy that has in effect on the date of service, an agreement with the PPO to provide Mail Order Prescription Drugs to Members under the provisions of this Certificate, and is so designated by the PPO.

i) **Preferred Pharmacy** means a pharmacy which has in effect on the date of service, an agreement with the PPO to provide Prescription Drugs to Members under the provisions of this Certificate, and is so designated by the

PPO. For pharmacies that are not in the PPO's Service Area, Prescription Drugs or refills may be filled at pharmacies contracted through the PPO's claims processor.

j) **Prescription Drug** means any drug or medicine required by Pennsylvania or Federal law to be dispensed by a licensed pharmacist or physician, upon written or oral prescription of a physician, subject to Section 4.56 of this Certificate and which is prescribed for use as an outpatient. Prescription Drug also includes contraceptives and diaphragms. Prescriptions requiring compounding will be covered if they contain one or more medications required by Pennsylvania or Federal law to be dispensed only by prescription and must be approved by the PPO. Prescription Drug does not include those drugs expressly excluded under Section 4.56 of this Certificate.

3.24.2 **Prescription Drug Tiers.** Prescription Drug Tiers are subject to the Cost Sharing amounts as set forth on the Schedule of Benefits. Drugs in each tier may require Precertification in order for the drugs to be Covered Services. Please refer to Section 3.24.3 of this Certificate. The Prescription Drug Tiers are set forth as follows:

a) **1st Tier** – This includes all preferred Generic Drugs which have the lowest Copayment. Prior Authorization or Precertification is usually not necessary for drugs in this tier.

b) **2nd Tier** – This includes all non-preferred Generic Drugs which have the second lowest Copayment. Prior Authorization or Precertification is usually not necessary for coverage of drugs in this tier.

c) **3rd Tier** – This includes certain high-cost Generic Drugs as well as preferred Brand Name Drugs which typically don't have a Generic equivalent. Precertification may be necessary for coverage of drugs in this tier.

d) **4th Tier** – This includes all non-preferred Brand Drugs which often have a generic equivalent and will have the highest Brand Drug Copayment. Prior Authorization or Precertification may be necessary for coverage of drugs in this tier.

e) **5th Tier** – This includes certain select high-cost specialty medications which typically require special dosing or administration and are typically prescribed by a Specialist. Drugs in this tier have a Coinsurance. Prior Authorization or Precertification may be necessary for coverage of drugs in this tier. Prescription Drugs in this tier are not available through Mail Order or for more than a thirty-four (34) day supply.

f) **6th Tier** – This includes preventive vaccinations as provided in Exhibit 4, Preventive Services and Generic oral contraceptives (single source brands) as provided in Exhibit 4, Preventive Services or additional drugs with no Cost Sharing.

*NOTE: The Drug Formulary (available on the website at www.thehealthplan.com or by request through the Customer Service Team at the number on the back of the Member ID Card) lists each drug covered by the PPO and the associated tier.

3.24.3 **Benefit.**

3.24.3.1 **Restricted Drugs and Drugs Requiring Prior Authorization Precertification**. Subject to the Cost Sharing as set forth on the Schedule of Benefits, and the limitations as set forth herein, restricted drugs or certain drugs requiring Prior Authorization or Precertification prescribed for a Member as a result of a Covered Service provided and covered under the terms of this Certificate, are covered only upon Prior Authorization or Precertification by the PPO and provided by a Preferred Pharmacy and/or Preferred Mail Order Pharmacy, as applicable.

3.24.3.2 Certain retail Preferred Pharmacy Providers may have agreed to make Maintenance Prescription Drugs available pursuant to the same terms and conditions, including Cost-Sharing and quantity limits, as the Mail Order Prescription drug coverage available under this Certificate. Members may contact the PPO at the toll-free number appearing on the back of the Member's Identification Card for a listing of those retail Preferred Pharmacy Providers who have agreed to do so.

3.24.3.3 **Over-the-Counter Medications.** The following over-the-counter medications are covered when an oral or written prescription for the item is provided by a Health Care Provider and the item is obtained from a Preferred Pharmacy or a Preferred Mail Order Pharmacy:

a. **iron supplementation** for children aged 6 through 12 months (only iron supplements are covered, multi-vitamins are not covered);

b. **oral fluoride supplementation** for children between 6 months of age and age 6;

c. **folic acid** (containing 0.4 to 0.8 mg) as a daily supplement for women planning or capable of pregnancy;

d. **low dose aspirin** (at 81.0 mg strength only) is covered for men and women ages 45 to age 79; and

e. FDA approved female contraceptive drugs and devices for women with reproductive capacity.

3.24.4 **Limitations.** The following are Limitations to the Prescription Drug (Outpatient) Benefit.

a) **Quantity.**

1) **Outpatient Prescription Drugs**- The maximum quantity of any drug covered under this Section, per Prescription Drug or refill, is limited to not more than a quantity which will be used within a three-month period; however, applicable Cost Sharing will be applied to each 34-day supply. Vacation overrides are at the PPO's discretion. Additional quantity restrictions may apply in accordance with the Formulary or within this Section.

2) **Mail Order Prescription Drugs-** The quantity of any Mail Order Prescription Drug under this Section, per prescription or refill, is a quantity required to last for a period of (ninety) 90 days. Additional quantity restrictions may apply in accordance with the Formulary or within this Section.

3) **Drugs Requiring Prior Authorization or Precertification.** Some drugs require Prior Authorization or Precertification in order for the drugs to be Covered Services. These drugs are identified in the Drug Formulary. Requests for Prior Authorization or Precertification must be directed to the PPO's Pharmacy Services Team.

b) **Non-Formulary Drugs**. Certain Prescription Drugs may not be included on the Drug Formulary. Prior Authorization or Precertification by the PPO is required for drugs not included on the Drug Formulary.

c) **Prenatal Vitamins and Fluoride.** A maximum of: (i) 100 tablets or capsules; or (ii) 50 ml in original package sizes of prenatal vitamins and vitamin fluoride combinations may be dispensed.

d) **Smoking Cessation Drugs: Chantix™ and Generic Zyban™ (buproban).** The following terms and conditions apply to the smoking cessation drugs Chantix™ and Generic Zyban™ (buproban):

1) **Chantix™ -** The PPO will cover the drug Chantix™ for the purpose of smoking cessation in accordance with the Formulary. Coverage for Chantix™ is limited to a Benefit Limit of 24 weeks per a Member's lifetime.

2) **Generic Zyban™ (buproban) -** The PPO will cover the Generic Drug Zyban™ (buproban) for the purpose of smoking cessation in accordance with the Formulary.

e) **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Prescription Drugs and Mail Order Prescription Drugs covered under this Section. Such restriction is subject to change by the PPO without the consent or concurrence of the Members, except as provided for herein.

f) **Assignment of Drugs to Tiers.** The PPO reserves the sole discretion in assigning drugs to certain tiers and in moving drugs from tier to tier. Several factors are considered when assigning drugs to tiers, including but not limited to: (i) the availability of a Generic equivalent; (ii) the absolute cost of the drug; (iii) the cost of the drug relative to other drugs in the same therapeutic class; (iv) the availability of over-the-counter alternatives; and/or (v) clinical and economic factors.

g) **Generic Drugs.** Whenever a Generic drug may legally be substituted for a brand name drug, this benefit applies only to the cost of the Generic drug, unless the Brand Name Drug is less costly, or unless the brand name is listed as payable on the Drug Formulary. If the prescription is written so as to require a pharmacist to dispense the Brand Name Drug, or if the Covered Person elects to receive the Brand Name Drug, the Member must pay any additional cost above the cost of the Generic Drug, in addition to any applicable Cost Sharing. Such payment is to be made to the pharmacy filling the prescription at the time the prescription is filled.

h) **Cost Sharing**. Prescriptions Drugs and Mail Order Prescription Drugs are subject to the Cost Sharing as set forth on the Schedule of Benefits.

i) **Own Use.** Prescription Drugs covered under this Certificate shall be solely for the use of the Member for whom the drugs were prescribed.

3.25 Physician Services.

3.25.1 **Hospital and Ambulatory Surgical Center Physician Services.** The services listed in Section 3.15.1 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

a) **Hospital.** The services set forth in Section 3.15.1 of this Certificate are Covered Services when provided by physician Providers (or other physicians in response to an emergency) or under the orders of a physician and are provided in a hospital while the Member is admitted to the hospital as a registered bed patient or is being treated as a hospital outpatient.

b) **Ambulatory Surgical Center**. The services set forth in Section 3.15.1 of this Certificate are Covered Services when provided in an Ambulatory Surgical Center setting by physician Providers (or other physicians in response to an emergency) or under the orders of a physician.

3.25.2 **Covered Physician Services in a Hospital or Ambulatory Surgical Center include**:

a) surgical procedures; anesthesia; and consultation with and treatment by consulting physicians; and

b) inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in an acute hospital **EXCEPT** if the Member is an inpatient in a psychiatric unit or in a mental hospital. Inpatient psychiatric unit and mental health services by licensed psychiatrist, clinical psychologist or other licensed behavioral health professional are covered as set forth in Section 3.20 of this Certificate.

3.25.3 **Physician's Offices.** The following services are considered a Covered Services in a physician's office:

a) Preventive, diagnostic and treatment services listed in Section 3.26 and Exhibit 4, **Preventive Services** in this Certificate;

b) cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer;

c) injectable drugs (including those injectable drugs listed in Section 3.30 of this Certificate) when determined by the Provider to be an integral part of care rendered by the Provider during a visit, limited to the amount of drug administered during the visit. Section 2 of this Certificate sets forth the list of agents/medications requiring Precertification by the PPO;

d) diagnostic and treatment Covered Services provided by a Specialist;

e) Medically Necessary Covered Services upon Precertification by the PPO received from Providers who are Non-Preferred Providers when the Member's medical condition requires Covered Services that cannot be provided through Preferred Providers and/or certain procedures and services designated by the PPO. These services shall be covered at the Preferred Provider rate.

3.25.4 **Primary Care Office Visits.** Office visits for Primary Care Services are covered.

3.25.5 **Specialist Office Visits.** Office visits for specialty care services are covered.

3.26 Preventive Services. The following preventive health care services are covered:

3.26.1 Periodic health assessments including:

a) physical examination (s),

3.26.1.1 **Periodic Health Assessment Cost Sharing.** For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.26.1, above, refer to the Schedule of Benefits under "PHYSICIAN OFFICE SERVICES". The Cost Sharing associated with these Covered Services will differ depending upon whether the services were provided by a Primary Care Physician or a Specialist.

3.26.2 **Additional Preventive Services listed in Exhibit 4.** The preventive services listed in **Exhibit 4** are not subject to Cost Sharing when obtained from a Preferred Provider.

3.27 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered for up to thirty-six (36) visits per Benefit Period.

3.28 Rehabilitative Services. Upon Precertification by the PPO in accordance with Section 2 of this Certificate, physical, occupational and speech therapy, on either an outpatient or inpatient basis, are covered for up to thirty (30) visits per Benefit Period. This thirty (30) visit limit is for any combination of physical, occupational and speech therapy Covered Services received within the Benefit Period. The Member should note that if more than one rehabilitative service is received on a particular day, this will only count as one visit towards the thirty (30) visit limit. For physical therapy related to the Back Pain Management Program, see Section 3.3.1.

3.29 Restorative or Reconstructive Surgery. Services are limited to the following:

3.29.1 **Congenital Defect or Birth Abnormality.** Restorative or reconstructive surgery to correct a medically diagnosed congenital defect or birth abnormality.

3.29.2 **Sickness, Accidental Injury or Incidental to Surgery.** Upon Precertification by the PPO, covered surgery performed to reasonably restore a Member to the approximate physical condition they were in prior to the defect resulting from a covered sickness, accidental injury or incidental to surgery.

3.30 Select Injectable Drugs. Subject to the terms and conditions set forth in Section 2 of the Certificate, the following injectable drugs are a Covered Service. Such injectable drugs are subject to the Cost Sharing on the Schedule of Benefits and the PPO's right to approve the Preferred pharmacy vendor for injectable drugs.

- Actemra ™ (tocilizumab)
- Acthar HP™ (repository corticotropin)
- Adcetris™ (brentuximab vedotin)
- Aldurazyme™ (laronidase)
- Alimta™ (pemetrexed)
- Amevive™ (alefacept)
- Aralast™ (human alpha$_1$-proteinase inhibitor)
- Aranesp™ (darbepoetin alfa)
- Arranon™ (nelarabine)
- Arzerra™ (ofatumumab)
- Avastin™ (bevacizumab)
- Benlysta™ (belimumab)
- Berinert™ (C1 Esterase Inhibitor Human)
- Boniva™ IV (ibandronate sodium)
- Botox™ (botulinum toxin type A)
- Ceredase™ (alglucerase)
- Cerezyme™ (imiglucerase)
- Cimzia™ (certolizumab pegol)
- Elaprase™ (idursulfase)
- Elelyso™ (taliglucerase alfa)
- Cinryze™ (C1-esterase inhibitor)
- Eligard™ (leuprolide)
- Eloxatin™ (oxaliplatin injection)
- Epogen™ (epoetin alfa)
- Erbitux™ (cetuximab)
- Euflexxa™ (hyaluronate sodium)
- Eylea™ (a flibercept)
- Fabrazyme™ (agalsidase beta)
- Firmagon™ (degarelix)
- Flolan™ (epoprostenol)
- Folotyn™ (pralatrexate)
- Glassia™ (alpha 1- proteinase inhibitor, human)
- Halaven-T™ (eribulin mesylate)
- Herceptin™ (trastuzumab)
- Hyalgan™ (hyaluronate sodium)
- IVIG™ (intravenous immune globulin)
- Ilaris™ (canakinumab)
- Invega Sustenna™ (paliperidone palmitate)
- Istodax™ (romidepsin)
- Ixempra™ (ixabepilone)
- Jevtana™ (cabazitaxel)
- Kalbitor™ (ecallantide)
- Kepivance™ (palifermin)
- Krystexxa™ (pegloticase)
- Lucentis™ (ranibizumab)
- Lumizyme™ (alglucosidase alfa)
- Lupron Depot™ (leuprolide acetate)
- Macugen™ (pegaptanib)
- Mozobil™ (plerixafor)
- Naglazyme™ (galsulfase)
- Neulasta™ (pegfilgrastim)

- Neupogen™ (filgrastim)
- Nplate™ (romiplostim)
- Omontys™ (peginesatide)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Orthovisc™ (hyaluronate sodium)
- Perjeta™ (pertuzumab)
- Prialt™ (ziconotide intrathecal infusion)
- Procrit™ (epoetin alfa)
- Prolastin™ (human alpha$_1$-proteinase inhibitor)
- Prolia™ (denosumab)
- Provenge™ (sipuleucel-T)
- Reclast™ (zoledronic acid)
- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Risperdal Consta™ (risperidone microspheres)
- Rituxan™ (rituximab)
- Simponi™ (golimumab)
- Soliris ™ (eculizumab)
- Stelara™ (ustekinumab)
- Supartz™ (hyaluronate sodium)
- Synagis™ (palivizumab)
- Synvisc™ (hylan G-F 20)
- Synvisc-1™ (hylan G-F 20)
- Thyrogen™ (thyrotropin alfa)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Trelstar™ (triptorelin)
- Tysabri™ (natalizumab)
- Vectibix™ (panitumumab)
- Velcade™ (bortezomib)
- Veletri™ (epoprostenol)
- Viadur™ (leuprolide)
- Vistide (cidofovir)
- Visudyne™ (verteporfin)
- Vivaglobin™ (subcutaneous immune globulin)
- Vivitrol™ (naltrexone microspheres)
- VPRIV™ (velaglucerase alfa)
- Xgeva™ (denosumab)
- Xiaflex™ (collagenase clostridium histolyticum)
- Xolair™ (omalizumab)
- Yervoy™ (ipilimumab)
- Zemaira™ (human alpha$_1$-proteinase inhibitor)

3.31 Skilled Nursing Facility Services. Services are limited to the following and require Precertification by the PPO in accordance with Section 2 of this Certificate: Covered Services, including room and board on a skilled bed status, in a skilled nursing facility, is covered for one hundred and twenty (120) days per Benefit Period.

3.32 Substance Abuse. Substance Abuse Services obtained from a Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Substance Abuse Services" Cost Sharing as set forth on the Schedule of Benefits. Substance Abuse Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Substance Abuse Professional Services" Cost Sharing set forth on the Schedule of Benefits. The following Substance Abuse services are covered:

3.32.1 **Definitions.** For the purpose of this Substance Abuse Section only, the following definition shall apply.

a) **Detoxification** means the process whereby an alcohol or drug intoxicated or dependent Member is assisted in a facility or by a Provider through the period of time necessary to eliminate by metabolic or other means 1) the intoxicating alcohol or drugs, 2) the alcohol and drug dependency factors or 3) alcohol in combination with drugs as determined by a Provider Physician, while minimizing the physiological risk to the Member.

b) **Opioid** refers to natural and synthetic chemicals that have opium-like narcotic effects when ingested. Opioids include pain medications such as Vicodin™ and OxyContin™.

3.32.2 **Inpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse is covered upon Precertification when provided on an inpatient basis in a hospital Provider or in an inpatient non-hospital facility. Services obtained from a Provider which participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Inpatient Hospital Detoxification Services" Cost Sharing as set forth on the Schedule of Benefits. Inpatient Detoxification Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Inpatient Hospital Detoxification Services" Cost Sharing set forth on the Schedule of Benefits. The following inpatient Detoxification Services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.32.3 **Acute Outpatient Opioid Detoxification Treatment**. Acute outpatient opioid Detoxification treatment is covered when provided by a Preferred Provider or a Provider who participates in the PPO's Designated Behavioral Health Benefit Program. Services obtained from a Provider which participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Acute Outpatient Opioid Detoxification Treatment Services" Cost Sharing as set forth on the Schedule of Benefits. Acute Outpatient Opioid Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Acute Outpatient Opioid Detoxification Services" Cost Sharing set forth on the Schedule of Benefits.

3.32.4 **Substance Abuse Rehabilitation.** The following Substance Abuse rehabilitation services are covered:

3.32.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered upon Precertification. Services obtained from a Provider which participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Non-Hospital Residential Rehabilitation Services" Cost Sharing as set forth on the Schedule of Benefits. Non-Hospital Residential Rehabilitation Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Non-Hospital Residential Rehabilitation Services" Cost Sharing set forth on the Schedule of Benefits. The following inpatient non-hospital residential care services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.32.4.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered upon Precertification. Services obtained from a Provider which participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Outpatient Rehabilitation Services" Cost Sharing as set forth on the Schedule of Benefits. Outpatient Rehabilitation Services obtained from a Provider who does not participate in the Designated Behavioral Health Benefit Program are subject to the Non-Preferred Provider "Outpatient Rehabilitation Services" Cost Sharing set forth on the Schedule of Benefits. The following Outpatient facility rehabilitation services for Substance Abuse are covered when administered by an employee of the facility: physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.32.4.3 **Partial Hospitalization.** In addition to the annual benefits set forth above, the PPO's Designated Behavioral Health Provider may authorize partial hospitalization services for Substance Abuse rehabilitation each Benefit Period.

*** NOTE: The use of a Non-Preferred Provider under this Section 3.32 rather than a Provider who participates in the Designated Behavioral Health Benefit Program may subject the Member to significant out-of-pocket expense**.

3.33 Transplant Services and Authorization Requirements.

3.33.1 **Covered Services.** Upon Precertification, hospital, physician, organ procurement, tissue typing and ancillary services related to the following transplants are covered when provided in a Designated Transplant Facility:

(i) bone marrow (allogeneic and autologous);
(ii) cornea (does not require Precertification);

(iii) heart;
(iv) heart and lung;
(v) kidney;
(vi) kidney and pancreas;
(vii) liver;
(viii) liver and kidney;
(ix) lung (single or double);
(x) pancreas transplant after successful kidney transplant;
(xi) small bowel; and
(xii) stem cell.

Members who have received a covered transplant under this Certificate may also receive coverage by the PPO's Designated Transplant Facility for certain services that would not otherwise be provided for under this Certificate.

3.33.2 **Precertification.** All transplant surgery and transplant-related services (with the exception of corneal transplants) require Precertification by the PPO. Medical criteria for any approved transplants will be applied and each potential transplant must be appropriate for the medical condition for which the transplant is proposed. Corneal transplants are covered when Medically Necessary and performed through a Preferred Provider.

3.33.3 **Covered Services for Patient Selection Criteria**. Covered Services for patient selection criteria shall be covered at one (1) Designated Transplant Facility. Should the Member request payment for Covered Services and supplies for patient selection criteria at more than one (1) transplant center, the expenses shall be the responsibility of the Member. This includes the Member's desire to be placed on more than one (1) procurement list for organ acquisition or for another transplant medium.

3.33.4 **Additional Opinion Policy for Transplants.** If a Member receives written notification from the PPO indicating the Member is ineligible for a transplant procedure by a Designated Transplant Facility, the Member may request a second opinion by another Designated Transplant Facility. The Member must contact the PPO to request a second opinion. If the second Designated Transplant Facility also determines the Member is not eligible for the transplant procedure, no coverage will be provided for further transplant-related services. If the second Designated Transplant Facility's opinion differs from the opinion of the first Designated Transplant Facility's opinion, a third opinion may be initiated by the PPO to obtain adequate information to make a determination regarding the proposed transplant procedure.

3.33.5 **Organ Donation.** Covered Services required by a Member as an organ donor for transplantation into another Member are covered upon Precertification by the PPO. Medical expenses of non-Member donors of organs for transplantation into a Member are covered only:

a) when the organ transplantation is approved by the PPO;

b) for the medical expense directly associated with the organ donation; and

c) to the extent not covered by any other program of insurance.

3.33.6 **Self-Administered Prescription Drugs.** Except as set forth in this Section, self-administered prescription drugs provided on an outpatient basis to Members are **NOT**

COVERED except as may be explicitly provided under Section 3.24 Outpatient Prescription Drugs.

3.33.6.1 Self-administered prescription drugs provided on an outpatient basis to non-Member donors of organs for transplantation into a Member are:

a) covered only when the organ transplantation is approved by the PPO;

b) limited to the prescription drug expense directly associated with the organ donation; and

c) covered only to the extent not covered by any other program or insurance.

3.33.7 **Travel, Lodging and Meal Expense Reimbursement.** Certain expenses for travel, lodging and meals incurred in conjunction with the occurrence of a Member's transplant procedure will be reimbursed to a Member organ recipient, a Member donor and/or a non-Member donor of organs (as applicable) at a two-hundred dollar ($200.00) daily limit up to a total maximum amount of five-thousand dollars ($5,000.00) per transplant in accordance with PPO guidelines. For information on submitting receipts and the PPO's specific guidelines for travel, lodging and meal reimbursement, please contact the Customer Service Team at the telephone number of the back of the Member's Identification Card.

3.33.8 **Retransplantation Services.** Retransplantation surgery and retransplantation-related services require Precertification by the PPO.

3.34 Transportation Services. The following transportation services by land or air ambulance are covered:

3.34.1 **Emergency Services.** Transportation services by land or air ambulance are covered when provided in response to an emergency for a condition which meets the definition of Emergency Services as set forth under this Certificate.

3.34.2 **Scheduled Services.** Medically Necessary non-emergency ambulance transportation is covered when provided by Preferred Providers subject to the Cost Sharing set forth on the Schedule of Benefits.

3.35 Urgent Care. Urgent Care services received through Preferred Providers in the Service Area are covered. Urgent Care services obtained from a Non-Preferred Provider outside of the Service Area are covered at the Preferred Provider rate when they are provided in response to a sudden and unexpected need for medical care while the Member is outside the Service Area which cannot be deferred until the Member's return to the Service Area. The Cost Sharing for Urgent Care is set forth on the Schedule of Benefits.

3.36 Urological Supplies. Urinary supplies provided by a Preferred Provider are covered when the PPO determines the Member has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in the Member within three (3) months.

3.37 Vision Services. Vision services are covered subject to the Exclusions in Section 4.57 as follows:

3.37.1 **Adult Vision Services.** Adults age nineteen (19) and older are covered for one routine eye examination to determine the refractive error of the eye per Benefit

Period. No referral is necessary. Services must be performed by a Preferred Provider who is: (i) a Doctor of Optometry; or (ii) a Medical Doctor who specializes in Ophthalmology.

3.37.2 **Pediatric Vision Services**. Children under age nineteen (19) are covered for one routine eye examination to determine the refractive error of the eye per Benefit Period. No referral is necessary. Services must be performed by a Preferred Provider who is: (i) a Doctor of Optometry; or (ii) a Medical Doctor who specializes in Ophthalmology.

3.37.2.1 **Prescription Eyewear**. Subject to the Exclusions in Section 4.57, children under age nineteen (19) are covered for a) one pair of eye glasses (lenses and frames) per two Benefit Periods or b) contact lenses subject to the Cost Sharing set forth on the Schedule of Benefits. Such eye glasses and contact lenses are covered when prescribed for vision correction by a licensed ophthalmologist or optometrist. Lens coatings and/or treatments that will be made a permanent part of the eyewear are also considered to be prescription eyewear.

3.37.2.2 **Prescription Eyewear Vendor**. Prescription eyewear must be obtained from a professional or commercial vendor licensed to dispense prescription eyewear (a Prescription Eyewear Vendor). A Prescription Eyewear Vendor may be a Preferred or Non-Preferred Provider.

3.38 Voluntary Family Planning Services. Voluntary family planning services include the professional services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Certificate in Section 4.25).

3.39 Weight Management Program. The PPO offers a program for weight management that includes education and management for appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. Weight management program services are covered when provided by the PPO's designated vendors. The Member should contact the Customer Service Team at the telephone number on the back of the Member's Identification Card for specific information on how to access the PPO's designated weight management program vendors.

3.40 Wisdom Teeth – Impacted. The PPO will pay the cost of services, including consultation, for the extraction of partially or totally bony impacted third molars when performed by a Preferred Provider as set forth below in Section 3.40.1 and subject to the Exclusions set forth in Section 4.58.

3.40.1 **Hospital and Ambulatory Surgical Center Services**. Hospital and Ambulatory Surgical Center services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, are covered if the hospital or Ambulatory Surgical Center services are required for an existing medical condition unrelated to the dental or oral surgical procedure or as set forth in Certificate Section 3.11**, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**. Such coverage requires Prior Authorization by the PPO**.**

SECTION 4. EXCLUSIONS

4. EXCLUSIONS. THE FOLLOWING ARE NOT COVERED by the PPO under this Certificate unless they are specifically provided as a Supplemental Health Service under the terms of a Rider (all of which are listed on a Member's Schedule of Benefits). If a Member does not have a Rider covering a service listed in this Section and he or she receives the service, the Member will be financially responsible for all charges or fees associated with the service.

4.1 Alternative Therapies. The following alternative therapies are **NOT COVERED**:

a) acupuncture;
b) ayurveda;
c) biofeedback;
d) craniosacral therapy;
e) guided imagery;
f) hippotherapy;
g) homeopathy;
h) massage therapy;
i) naturopathy;
j) reiki;
k) therapeutic touch; and/or
l) yoga.

4.2 Any Cost for Services Obtained From Non-Preferred Providers That Exceeds the PPO's Then Current Non-Preferred Provider Fee Schedule Amount. Any cost for services obtained from Non-Preferred Providers that exceeds the PPO's then current Non-Preferred Provider Fee Schedule Amount is **NOT COVERED,** except with respect to Emergency Services as set forth in Section 3.9.2 of this Certificate or when Covered Services are not available from a Preferred Provider.

4.3 Batteries Required for Diabetic Medical Equipment. Batteries required for diabetic medical equipment are **NOT COVERED.**

4.4 Behavioral Services. Any treatment or care related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavioral problems and mental retardation, which extend beyond traditional medical management are **NOT COVERED**, except as may be provided in Section 3.2 **Autism Spectrum Disorder Covered Services**, Section 3.12 **Habilitative Services** and Section 3.20**, Mental Health Services** of this Certificate.

4.5 Blood or Other Body Tissue and Fluids, Including Storage. Blood and its components or any artificially created blood products are **NOT COVERED.** Storage of blood, including autologous and cord blood, other body tissue and fluids is **NOT COVERED.**

4.6 Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.18 of this Certificate.

4.7 Charges Covered under Certain Acts or Laws. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the

Pennsylvania Motor Vehicle Financial Responsibility Law are **NOT COVERED**. This exclusion applies regardless of whether the Member claims the benefit compensation.

4.8 **Corrective Devices.** The purchase, fitting, or adjustment of corrective devices including but not limited to, eyeglasses, contact lenses, and hearing aids, are **NOT COVERED** except as provided in Section 3.37, **Vision Services**.

4.9 **Cosmetic Surgery.** Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO, is **NOT COVERED**. This exclusion does not apply to Covered Services set forth in Sections 3.18, 3.29.1 or 3.29.2 of this Certificate.

4.10 **Custodial, Convalescent or Domiciliary Care.** Custodial, Convalescent or Domiciliary Care services are **NOT COVERED**.

4.11 **Dentistry.** The PPO does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the PPO will cover: a) expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.22.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth); b) General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.11 and c) extraction of partially or totally bony impacted third molars (wisdom teeth) as set forth in Section 3.40, **Wisdom Teeth - Impacted**.

4.12 **Drug Maintenance Programs**. Drug maintenance programs for the outpatient treatment of drug Detoxification, dependency or addiction are **NOT COVERED**.

4.13 **Drugs and Devices for Purposes of Contraception.** Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of **Exhibit 4, Preventive Services** and **Section 3.24**, **Outpatient Prescription Drugs.**

4.14 **Elective Abortions.** Abortions are **NOT COVERED** except for those that are Medically Necessary to avert the death of the mother, or to terminate pregnancy caused by rape or incest.

4.15 **Experimental, Investigational or Unproven Services.** Experimental, investigational or unproven services are **NOT COVERED**. This exclusion does not apply to a qualified Member's participation in an approved clinical trial for cancer or life-threatening disease or condition.

4.16 **Failure to Obtain Precertification.** The following services are **NOT COVERED** when they are obtained from a Non-Preferred Provider prior to Precertification by the PPO:

4.16.1 All non-emergency inpatient hospital admissions; and

4.16.2 the procedures and services set forth in Exhibit 3 of this Certificate, **Precertification List.**

4.17 **Foot Care Services.** Except for Members with diabetic conditions, the treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet and chronic foot strain are **NOT COVERED**.

4.18 **Gender Reassignment.** Transplants, implants, procedures, services and supplies related to gender reassignment are **NOT COVERED**.

4.19 **General Anesthesia for Temporal Mandibular Joint Disorders (TMJ).** General Anesthesia for dental care rendered for (TMJ) is **NOT COVERED.**

4.20 **Government Responsibility.** Care for military service related disabilities if the care is being provided in a U.S. Military Facility for which the Member does not incur a legal responsibility to pay for such care is **NOT COVERED**.

4.21 **Government-Sponsored Health Benefits Program**. Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are **NOT COVERED**. All required Precertifications must be obtained even when the PPO is the secondary carrier.

4.22 **Hair Removal**. Hair removal is **NOT COVERED**.

4.23 **Hypnosis.** Hypnosis is **NOT COVERED**.

4.24 **Illegal Activity.** Covered Services required as a result of a Member's commission of or attempt to commit a felony or being engaged in an illegal occupation, are **NOT COVERED**.

4.25 **Infertility Procedures.** In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), embryo transplants, artificial insemination and similar procedures as determined by the PPO are **NOT COVERED**. Expenses incurred or Covered Services required for any infertility procedures resulting from a Member's or a Member's spouse's voluntary sterilization are **NOT COVERED**. Sperm, ova and embryo storage are **NOT COVERED**.

4.26 **Insertion and Removal of Non-Covered Implanted Devices**. Any costs, charges or fees associated with the insertion, fitting or removal of an implanted device, when such device is not covered under the terms of this Certificate, are **NOT COVERED.**

4.27 **Insured Obligations.** The following amounts are **NOT COVERED:**

i) amounts for any Covered Service which are greater than the PPO's then current Non-Preferred Provider Fee Schedule Amount (except with respect to costs associated with Emergency Services or when Covered Services are not available from a Preferred Provider);
ii) amounts for any Covered Service which are applied toward satisfaction of the Copayment, Deductible or Coinsurance amounts; or
iii) amounts which exceed the specific Benefit Limits set forth on the Schedule of Benefits.

4.28 **Intoxication or Narcotic Influence.** Care, treatment or service for any loss sustained or contracted in consequence of the Member's being intoxicated, or under the influence of any narcotic unless administered on the advice of a physician is **NOT COVERED**.

4.29 **Missed Appointment Charge.** Charges for missed appointments by a Member are **NOT COVERED.**

4.30 **No Obligation to Pay.** Any type of drug, service, supply or treatment for which the Member would have no legal obligation to pay, is **NOT COVERED.**

4.31 **Non-Rigid Elastic Garments.** Non-rigid elastic garments are **NOT COVERED**.

4.32 **Not Medically Necessary.** Covered Services which are not considered Medically Necessary by the PPO are **NOT COVERED** unless set forth as a Covered Service under Section 3.26 of the Certificate and Exhibit 4, **Preventive Services**.

4.33 **Oral Nutrition Products or Supplements.** Oral nutrition products or supplements not used to treat inborn errors of metabolism are **NOT COVERED** including, but not limited to:

a) supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc.;
b) lactose free foods;
c) banked breast milk; and/or
d) standardized or specialized infant formulas.

4.34 **Organ Donation to Non-Members.** All costs and services related to a Member donating organ(s) to a non-Member are **NOT COVERED**.

4.35 **Orthoptic Therapy.** Orthoptic therapy (vision exercises) is **NOT COVERED**.

4.36 **Panniculectomy, Lipectomy and Abdominoplasty.** Excision of excessive skin and subcutaneous tissue including but not limited to panniculectomy, abdominoplasty or lipectomy by any method (such as suction assisted liposuction or aspiration) is **NOT COVERED**. These procedures may involve areas such as, but not limited to, head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks and hips.

4.37 **Personal and Athletic Trainer Services**. Services provided by a personal or athletic trainer are **NOT COVERED**.

4.38 **Personal Comfort Items/Services.** Personal comfort items and services including but not limited to, telephones, televisions and special meals are **NOT COVERED**.

4.39 **Prescription Drug, Device or Equipment Use by a Non-Member**. Use by anyone other than the Member of a Prescription Drug, device or equipment provided to a Member according to the terms and conditions set forth in Section 3, **Covered Services**, of this Certificate is **NOT COVERED**.

4.40 **Prescription Bandages and Wound Dressings**. Outpatient Prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in Section 3.24 of this Certificate.

4.41 **Private Duty Nursing.** Hourly nursing care on a private duty basis is **NOT COVERED** except for Medically Necessary acute hospital private duty registered nurse services.

4.42 **Refractive Procedures.** Any surgery to correct the refractive error of the eye is **NOT COVERED**.

4.43 **Reversal of Sterilization.** Surgical procedures to reverse voluntary sterilization are **NOT COVERED**.

4.44 Revision of the External Ear. Revision of the external ear is **NOT COVERED**.

4.45 Riot or Insurrection. Covered Services required as a result of a Member's participation in a riot or insurrection, are **NOT COVERED**.

4.46 Routine Nail Trimming. Routine nail trimming is **NOT COVERED**.

4.47 Services Provided by a Member's Relative or Self. Services rendered by a physician Provider who is the spouse, child, parent, grandparent, aunt, uncle, niece or nephew, sibling or persons who ordinarily reside in the household of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.

4.48 Services Provided in Conjunction with a Non-Covered Service. Any service, which would otherwise be a Covered Service under this Certificate, when provided in conjunction with the provision of a non-Covered Service, is **NOT COVERED**. Such services may include but are not limited to anesthesia or diagnostic services. This exclusion does not include Medically Necessary Covered Services incurred due to complications resulting from a Member's receipt of a non-Covered Service or General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.11.

4.49 Sexual Dysfunction Services, Devices and Equipment. Sexual dysfunction services, devices and equipment, male or female, are **NOT COVERED**.

4.50 Surgery for Treatment of Morbid Obesity. Surgical treatment of morbid obesity is **NOT COVERED**.

4.51 Transportation Services. Stretcher/wheelchair van transportation or transportation services that are not Medically Necessary are **NOT COVERED**.

4.52 Vein Sclerosing. Injection of sclerosing solution into superficial veins (commonly called spider veins) is **NOT COVERED**. Injection of sclerosing solution into varicose leg veins is **NOT COVERED** unless Medically Necessary.

4.53 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless as provided for in Section 3.39 of this Certificate or Exhibit 4, Preventive Services.

4.54 THE FOLLOWING SERVICES ARE NOT COVERED WHEN OBTAINED FROM NON-PREFERRED PROVIDERS:

4.54.1 **Back Pain Management Program.** Back Pain Management Program services obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.2 **Corneal Transplants, Evaluation and Related Services.** Corneal transplants, evaluation and related services obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.3 **Diabetic Medical Equipment, Blood Glucose Monitors, Diabetic Foot Orthotics, Insulin and Oral Pharmacological Agents for Controlling Blood Sugar, Disposable Syringes and Blood Glucose Monitor Supplies (Lancets and Blood Glucose Test Strips) and Outpatient Training and Education.** Diabetic medical equipment, blood glucose monitors, foot orthotics, insulin and oral pharmacological agents for controlling blood sugar, disposable syringes, blood

glucose monitor supplies (lancets and blood glucose test strips) and outpatient training and education are **NOT COVERED**.

4.54.4 **Durable Medical Equipment, Orthotic Devices and Prosthetic Devices.** Durable Medical Equipment, Orthotic Devices and Prosthetic Devices obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.5 **Enteral Feedings/Food Supplements.** Enteral feedings/food supplements obtained from Non-Preferred Providers are **NOT COVERED.**

4.54.6 **Foot Care Services.** Foot Care services obtained from Non-Preferred Providers are **NOT COVERED.**

4.54.7 **Genetic Counseling and Testing.** Genetic counseling and testing obtained from Non-Preferred Providers are **NOT COVERED.**

4.54.8 **Manipulative Treatment Services.** Manipulative Treatment Services obtained from a Non-Preferred are **NOT COVERED.**

4.54.9 **Ostomy Supplies**. Ostomy supplies obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.10 **Pain Management.** Pain management services obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.11 **Preventive Services.** Preventive Services are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.54.12 **Routine Eye Examinations**. Routine Eye Examinations are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.54.13 **Routine Physicals.** Routine Physicals are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.54.14 **Scheduled Transportation Services.** Scheduled Transportation Services obtained from a Non-Preferred Provider are **NOT COVERED.**

4.54.15 **Urological Supplies**. Urological supplies obtained from Non-Preferred Providers are **NOT COVERED**.

4.54.16 **Well-Child Office Visits**. Well-child office visits are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.54.17 **Well-Woman Examination**. Well-Woman Examinations are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.54.18 **Wisdom Teeth – Impacted**. Extraction of partially or totally bony impacted third molars (wisdom teeth) as set forth in Section 3.40, **Wisdom Teeth – Impacted,** are **NOT COVERED** when obtained from a Non-Preferred Provider.

4.55 THE FOLLOWING DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC DEVICES AND PROSTHETIC DEVICES ARE NOT COVERED:

4.55.1 **Access Ramps** for home or automobile are **NOT COVERED.**

4.55.2 **Anodyne Infrared Therapy.** Anodyne infrared therapy is **NOT COVERED.**

4.55.3 **Batteries** for DME, Orthotic Devices and/or Prosthetic Devices are **NOT COVERED**.

4.55.4 **Cold Therapy and/or Ice Packs**. Continuous hypothermia machine cold therapy and/or ice packs are **NOT COVERED**.

4.55.5 **Computerized Devices and Communicative Equipment.** Communicative equipment or devices, computerized assistive devices and communication boards are **NOT COVERED**.

4.55.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** of any sort, except for diabetic foot orthotics which are covered as a Covered Service under Section 3.5.2 of this Certificate, are **NOT COVERED**.

4.55.7 **Deluxe Equipment or Devices.** Deluxe Equipment or devices of any sort are **NOT COVERED.**

4.55.8 **Dental Appliances** of any sort including, but not limited to, bridges, braces and retainers are **NOT COVERED**.

4.55.9 **Disposable Supplies** which include but are not limited to, gloves, ace bandages, self-administered catheters, spacer devices for meter dose inhalers, peak flow meters or incentive spirometers are **NOT COVERED.**

4.55.10 **Exercise Equipment or Facilities**. Exercise equipment such as whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools and saunas are **NOT COVERED.**

4.55.11 **Experimental or Research Equipment** which, as determined by the PPO, is not accepted as standard medical treatment of the condition being treated, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device, Orthotic Device or DME was provided is **NOT COVERED**. The experimental or non-experimental nature of any Prosthetic Device, Orthotic Device, or DME shall be determined by the PPO in accordance with the terms and conditions set forth in Section 1.24 of this Certificate.

4.55.12 **Home Monitoring Equipment** other than apnea monitors and pulse oximeters for Members over age eighteen (18), are **NOT COVERED.**

4.55.13 **Items for Personal Comfort or Convenience.** Items which are primarily for personal comfort or convenience, including but not limited to bed boards, air conditioners and over-bed tables are **NOT COVERED**.

4.55.14 **More than One Piece of Equipment** that serves the same function, including rental or back up of owned or rented equipment is **NOT COVERED**.

4.55.15 **Motor Driven or Deluxe Equipment** of any sort is **NOT COVERED.**

4.55.16 **Motor Vehicles or Vehicle Modifications**. Motor vehicles, or any modification to a motor vehicle (including but not limited to car seats) are **NOT COVERED**.

4.55.17 **No Longer Medically Necessary.** Any piece of equipment which is determined by the PPO to be no longer Medically Necessary is **NOT COVERED**.

4.55.18 **Non-Medical Self-help Devices**. Self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides are **NOT COVERED.**

4.55.19 **Non-Preferred Provider.** Unless approved in advance by the PPO, DME, Prosthetic Devices and/or Orthotic Devices which are obtained from a Non-Preferred Provider are **NOT COVERED**.

4.55.20 **Repair or Replacement** of any piece of equipment/device, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in Section 3.8.2 of this Certificate.

4.55.21 **Replacement of Component Parts or Modification** of a Prosthetic Device unless incident to the Member's growth for a Member who is under the age of nineteen (19) years as set forth in Section 3.8.4.1 of this Certificate is **NOT COVERED**.

4.55.22 **Specifically Listed Items, Devices and Equipment.** The following are **NOT COVERED:**

a) hairpieces and wigs;
b) seasonal affective disorder lights;
c) air filtration units;
d) vaporizers;
e) heating lamps;
f) pads, pillows and/or cushions;
g) hypoallergenic sheets;
h) paraffin baths;
i) vitrectomy face support devices; and
j) safety equipment (including but not limited to: gait belts, harnesses and vests).

4.56 THE FOLLOWING ARE NOT COVERED UNDER OUTPATIENT PRESCRIPTION DRUGS AS SET FORTH IN SECTION 3.24 OF THIS CERTIFICATE:

4.56.1 **Allergy Injections** are **NOT COVERED.**

4.56.2 **Any Brand Name Drug with any Variation or Degree of the Following FDA-Approved Indications**, regardless of prescribed use by a Provider or intended use by a Member is **NOT COVERED**:

i. Anxiety Disorders
ii. Attention Deficit/Hyperactivity Disorders
iii. Bipolar Disorders
iv. Depression
v. Eating Disorders (including, but not limited to, Bulimia and Anorexia)
vi. Obsessive Compulsive Disorders
vii. Panic Disorders

viii. Posttraumatic Stress Disorders
ix. Pre-menstrual Dysphonic Disorders
x. Psychotic Disorders
xi. Schizophrenia
xii. Substance Abuse Disorders (including, but not limited to, alcohol and drug abuse)

4.56.3 **Cosmetic Indications.** Prescription drugs prescribed for cosmetic indications are **NOT COVERED**, including but not limited to drugs for hair loss or growth, drugs for wrinkles or skin bleaching and drugs used for the treatment of onychomycosis (fungal nail infection).

4.56.4 **Dental Office**. Drugs prescribed or administered by a dentist for in dental office use are not covered except for those which are covered under Certificate Section 3.11, **General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**.

4.56.5 **Devices**. The following non-contraceptive and contraceptive devices are **NOT COVERED:**

i) **Non-contraceptive Devices**. Devices of any type, even if such devices may require a prescription, including but not limited to: therapeutic devices; artificial appliances; hypodermic needles and syringes (except those which are listed as a Covered Service in Section 3.5.3, **Diabetic Medical Equipment**); diagnostic devices and supplies.

ii) **Non-Prescription and/or Non-FDA Approved Contraceptive Devices.** Non-prescription contraceptive devices and/or non-FDA approved contraceptive devices, including but not limited to male condoms and implantable devices for the purpose of releasing contraceptive drugs.

4.56.6 Dietary supplements, vitamins (except prescription prenatal), fluoride supplements/rinses (except for those over-the-counter medications listed in Exhibit 4 of this Certificate), anabolic steroids, blood plasma products or irrigation solutions are **NOT COVERED**.

4.56.7 **Drugs Available without a Prescription**. Drugs written as Prescription Drugs which are available without a prescription in the same strength are **NOT COVERED**.

4.56.8 **Drugs which are not Prescription Drugs** as defined in Section 3.24.1(j) of this Certificate are **NOT COVERED**.

4.56.9 **Erectile Dysfunction Medications** are **NOT COVERED.**

4.56.10 **Experimental Drugs**, including those labeled "Caution-limited by Federal law to Investigational Use," non-FDA approved drugs, FDA approved drugs for investigational indications or for non-FDA approved uses or at investigational doses and drugs found by the FDA to be ineffective are **NOT COVERED**.

4.56.11 **Extemporaneous Dosage Forms of Natural Estrogen or Progesterone**, including but not limited to oral capsules, suppositories and troches are **NOT COVERED**.

5.56.12 **Food.** Any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide

nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis is **NOT COVERED**. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria which are covered under the terms and conditions of Certificate Section 3.10, **Enteral Feeding/Food Supplements.**

4.56.13 **Immunizations** are **NOT COVERED** except those as set forth as Preventive Services in **Exhibit 4** of this Certificate.

4.56.14 **Non-Drug Formulary Prescription Drugs**. Prescription Drugs which are not included on the Drug Formulary unless authorized in advance by the PPO are **NOT COVERED.**

4.56.15 **Non-Formulary Drugs**, restricted drugs or drugs requiring Precertification by the PPO which have been obtained prior to receiving such authorization are **NOT COVERED**.

4.56.16 **Non-Preferred Pharmacies**. Outpatient prescription drugs obtained from Non-Preferred Pharmacies are **NOT COVERED**.

4.56.17 **Not Medically Necessary.** Drugs that are not Medically Necessary as determined by the PPO are **NOT COVERED.**

4.56.18 **Over-the-Counter Drugs and Other Items Available without a Prescription**, whether provided with or without a prescription are **NOT COVERED**, including but not limited to aspirin, oxygen, cosmetics, medicated soaps, food supplements, vitamins and bandages.

4.56.19 **Prescription Bandages and other Wound Dressing Products** are **NOT COVERED.**

4.56.20 **Prescription Replacements** for lost, destroyed or stolen prescriptions are **NOT COVERED.**

5.56.21 **Repackaged Medications**. Medications that are repackaged by the supplier and sent to the pharmacy for fulfillment of prescriptions are **NOT COVERED**.

4.56.22 **Restricted Drugs or Drugs Requiring Precertification** by the PPO which have not received such authorization in advance are **NOT COVERED**. The PPO reserves the right to require Precertification for selected drugs (listed in the Drug Formulary) before providing coverage for such drugs.

4.56.23 **Smoking Cessation Aids**, including but not limited to nicotine replacement drugs (except Chantix™ and Generic Zyban™ (buproban) as described in Section 3.24.4 d) of this Certificate are **NOT COVERED.**

4.56.24 **Standard Medical Treatment**. Prescription drugs not accepted as standard medical treatment of the condition being treated as determined by the PPO, or any such drug requiring Federal or other governmental agency approval not granted at the time the drug was dispensed are **NOT COVERED**.

4.56.25 **The Prescription Drugs Suboxone™ and Subutex ™** or any Generic equivalents of these drugs are **NOT COVERED** unless they are prescribed by a Preferred

Provider or a Provider who participates in the PPO's Designated Behavioral Health Benefit Program.

4.56.26 **Unit Doses of Prescriptions**. Prescriptions dispensed in unit doses, when bulk packaging is available are **NOT COVERED.**

4.56.27 **Use of a Prescription Drug by Anyone other than the Member** listed on the prescription is **NOT COVERED.**

4.56.28 **Weight loss or Weight Management.** Prescription Drugs prescribed for weight loss or weight management are **NOT COVERED**.

4.57 THE FOLLOWING ARE NOT COVERED UNDER THE VISION SERVICES BENEFIT AS SET FORTH IN SECTION 3.37 OF THIS CERTIFICATE.

4.57.1 **Repairs**. Repairs to Prescription Eyewear are **NOT COVERED**.

4.57.2 **Shipping Charges.** Any shipping charges associated with the purchase or order of Prescription Eyewear are **NOT COVERED**.

4.57.3 **Warranties.** Supplemental warranties for Prescription Eyewear are **NOT COVERED**.

4.57.4 **Cleaning Accessories.** Cleaning kits and other cleaning accessories or solutions for Prescription Eyewear are **NOT COVERED**.

4.57.5. **Examinations and Procedures**. Laser vision corrective surgery and other medical and/ or surgical procedures related to the eye are **NOT COVERED**.

4.57.6 **Orthoptic and Vision Training**. Orthoptic and vision training are **NOT COVERED**.

4.57.7 **Eyeglass and Contact Accessories.** Eyeglass and contact accessories, which may include but are not limited to, carrying cases, holders, sunglass clip-lenses and repair kits, are **NOT COVERED.**

4.57.8 **Non-Prescription Eyewear.** Non-Prescription Eyewear, including but not limited to: eyeglasses, frames, lenses, sunglasses, safety glasses, magnification aids and contact lenses is **NOT COVERED**.

4.57.9 **Fittings**. Fittings for eyeglasses, lenses and contact lenses are **NOT COVERED**.

4.58 THE FOLLOWING ARE NOT COVERED UNDER THE WISDOM TEETH – IMPACTED, BENEFIT AS SET FORTH IN SECTION 3.40 OF THIS CERTIFICATE.

4.58.1 **Dental Care.** Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.

4.58.2 **Hospital Services**. Hospital services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, unless the hospital services are required for an existing medical condition unrelated

to the dental or oral surgical procedure.

4.58.3 **Non-Preferred Provider**. Impacted wisdom teeth services that are not obtained from Preferred Providers are **NOT COVERED.**

SECTION 5. APPEAL PROCEDURE

APPEAL PROCEDURE. Requests for an appeal must be submitted **in writing** and received by the PPO within **one hundred eighty (180) days** following the Member's receipt of the notification of an Adverse Benefit Determination (an Adverse Benefit Determination is any decision made by the PPO with respect to payment or service related issues that results in a denial).

*If a Member chooses to appeal an Adverse Benefit Determination, a **written request** must be submitted to:*

Geisinger Choice PPO
Appeal Department
100 North Academy Avenue
Danville, PA 17822-3220

At any time during any of the appeal processes outlined below, a Member may choose to designate in writing a representative to participate in the appeal process on the Member's behalf (an "Authorized Representative"). In this Section 5 of the Certificate, the definition of Member shall include a Member's Authorized Representative. The Member shall be responsible to notify the PPO in writing of such designation. The PPO has an authorization form available for the Member's use in order to designate an individual to act as the Member's Authorized Representative. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member's Identification Card.

Members have the right to provide the PPO with written comments, documents, records or other information to be considered as part of the appeal review.

A Member may call the PPO's toll-free telephone number located on the back of the Member's Identification Card, Monday through Friday from 8:00 a.m. through 6:00 p.m. to obtain information regarding the filing and status of an appeal.

When a Member submits a written request for an appeal, the PPO will complete a full and fair review and provide written notification of the PPO's decision to the Member within the following time frames:

Pre-Service Appeal – Not later than 30 days after the PPO receives the written request
Post-Service Appeal – Not later than 30 days after the PPO receives the written request
Urgent Care Appeal – Not later than 72 hours after the PPO receives the request

5.1 Pre-Service Appeal Procedure. A Pre-Service Appeal is a request to change an Adverse Benefit Determination for care or services that the PPO must approve, in whole or in part, in advance of the Member obtaining care or services.

A Member may request a Pre-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

5.1.1 **Pre-Service Appeal Review for Denials not based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the

Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the PPO. The PPO shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.1.2 **Pre-Service Appeal Review for Denial Based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the Adverse Benefit Determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the PPO shall provide the Member or the Health Care Provider with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the appeal. The Member and/or the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The PPO and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The PPO shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review meeting.

5.1.3 **Pre-Service Appeal Time Frame for Decision.** A Pre-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the Member's written request. The PPO shall provide the Member with a written notification of the PPO's decision no later than thirty (30) days from receipt. The written notification from the PPO will include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;

d) notification that the Member may request assistance with their appeal from the applicable state Office of Health Insurance Consumer Assistance; and

e) the Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.2 Post-Service Appeal Procedure. A Post-Service Appeal is a request to change an Adverse Benefit Determination for care or services that have already been received by the Member. A Member may request a Post-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

5.2.1 **Post-Service Appeal Review for Denials not based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the PPO. The PPO shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.2.2 **Post-Service Appeal for Denials based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the Adverse Benefit Determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the PPO shall provide the Member or the Health Care Provider with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the appeal. The Member and the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The PPO and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The PPO shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review Committee meeting.

5.2.3 **Post-Service Appeal Time Frame for Decision.** A Post-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the written request. The PPO shall provide the Member with written notification of the PPO's decision no later than thirty (30) days from receipt. The written notification from the PPO shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;

d) notification that the Member may request assistance with their appeal from the applicable state's Office of Health Insurance Consumer Assistance; and

e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.3 Urgent Care Appeal Procedure. A claim involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

a) could seriously jeopardize the life or health of the Member, or the ability of the Member to regain maximum function as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or

b) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

5.3.1 **Request of an Urgent Care Appeal**. A Member or a Member's Health Care Provider may request an Urgent Care Appeal either orally or in writing. The Member or the Member's Health Care Provider requesting the Urgent Care Appeal may contact the PPO by telephone, fax or other methods that will expedite receipt of the information by the PPO. The PPO will contact the requestor by telephone, fax or other prompt method to resolve the Member's appeal. The PPO will provide a full and fair review of the appeal.

5.3.2 **Review of an Urgent Care Appeal.** The PPO shall perform an Urgent Care Appeal Review and render a decision within seventy two (72) hours of receipt of the Member's request. The Member shall be responsible to provide information to the PPO in an expedited manner to allow the PPO to conform to the Urgent Care Appeal requirements. The Urgent Care Internal Review Committee shall be comprised of three (3) or more individuals one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the Adverse Benefit

Determination. The Urgent Care Appeal review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure, or provides the treatment and who was not previously involved in the matter under review. The PPO shall provide the Member with written notification of the PPO's decision that shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and

d) notification that the Member may request assistance with their Appeal from the applicable state's Office of Health Insurance Consumer Assistance; and

e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.4 External Appeal Review Procedure. If the Member is not satisfied with the Final Adverse Benefit Determination (a Final Adverse Benefit Determination is the decision made by the PPO in regard to an appeal filed in accordance with Sections 5.1, 5.2 or 5.3 above that results in a denial), the Member may have the opportunity to request an external review. Final Adverse Benefit Determinations that meet the federally regulated external appeal criteria are eligible for review by an IRO. Information regarding any appeal rights will be provided to the Member within the Appeal decision notification.

5.4.1 **Procedures for External Appeal Review.** The Member or the Health Care Provider, with the Member's written consent, who is dissatisfied with the Final Adverse Benefit Determination, may file a request for an external review with the PPO within **four (4) months** after the date of receipt of the notice of the Final Adverse Benefit determination.

5.4.1.1 **Preliminary Review Procedure.** Within five (5) days of receipt of the external review request, the PPO must complete a preliminary review of the request to determine whether:

a) The Member is or was covered under the PPO at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the PPO at the time the health care item or service was provided;

b) The adverse benefit determination or the Final Adverse Benefit Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of the PPO (e.g., worker classification or similar determination);

c) The Member has exhausted the PPO's internal appeal process, unless the Member is not required by applicable State or Federal regulation to exhaust the internal appeals process; and

d) The Member has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the PPO must issue written notification to the Member. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete. To complete an incomplete request, the Member will have either the remainder of the four (4) month filing period (as detailed in Section 5.4.2) or within forty-eight (48) hours following the receipt of the notification, whichever is later.

5.4.1.2 **External Review Procedure**. If an external review is warranted, the PPO will assign an independent review organization (IRO) as required by and in accordance with all applicable State and Federal regulations. The IRO will notify the Member of acceptance for external review and will inform the Member that they may submit in writing, within ten (10) business days, any additional information the Member would like the IRO to consider in the review. The IRO will perform an independent claim review and will not be bound by decisions or conclusions reached during the PPO's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

a) The Member's medical records;

b) The attending health care professional's recommendation;

c) Reports from appropriate health care professionals and other documents submitted by the PPO, Member, or the Member's treating Provider;

d) The terms of the Member's PPO plan to ensure that the IRO's decision is not contrary to the terms of the PPO plan, unless the terms are inconsistent with applicable law;

e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

f) Any applicable clinical review criteria developed and used by the PPO unless the criteria are inconsistent with the terms of the PPO plan or with applicable law; and

g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this Section 5.4.2.2 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

5.4.1.3 **Time Frame for Decision**. The IRO will provide written notice of the final external review decision to the Member and the PPO within forty-five (45) days after the IRO receives the request for external review. The decision will be in writing and will include the following:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial);

b) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c) References to the evidence or documentation including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

d) A discussion of the principal reason for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision;

e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the PPO or the Member;

f) A statement that judicial review may be available to the Member; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

5.4.1.4 **Binding Decision**. The Member and the PPO will be bound by the final decision of the IRO except to the extent that other remedies are available under State or Federal law. The requirement that the decision be binding shall not preclude the PPO from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require payment or benefits. The PPO must provide any benefits (including making payment on the claim)

pursuant to the final external review decision without delay, regardless of whether the PPO intends to seek judicial review of the external decision and unless or until there is a judicial decision.

5.4.2 **Expedited External Review Procedure.** The Member may make a request for an expedited external review at the time the Member receives:

(a) an Adverse Benefit Determination if the Determination involves a medical condition of the Member for which the timeframe for an internal urgent care appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function **and** the Member has filed a request for an internal urgent care appeal; or

(b) a final internal urgent care appeal if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final internal urgent care appeal concerns an admission, availability of care, continued stay or health care item or service for which the Member received emergency services but has not been discharged from a facility.

NOTE: Under certain circumstances, which will be outlined to the Member in the PPO's appeal correspondence, an expedited external review may be requested at the same time the Member requests an expedited appeal.

5.4.2.1 **Preliminary Review**. If the PPO determines the expedited external review request meets the requirements set forth in Section 5.4.2.1, notice will be sent to the Member within one (1) business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

5.4.2.2 **External Review Procedure**. If an external review is warranted, the PPO will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The PPO will provide all the necessary documents and information considered in making the Final Adverse Benefit Determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.2.2. In reaching a decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during the PPO's internal appeal procedures.

5.4.2.3 **Notice of the Final External Review Decision.** The IRO will provide notice of the final external review decision in accordance with Section 5.4.2.3 (a) through (g) as expeditiously as the Member's medical condition requires, but in no event later than seventy-two (72) hours after the IRO receives a request for an

expedited external review. If the notice from the IRO to the Member is not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Member and the PPO.

SECTION 6. ELIGIBILITY

6. ELIGIBILITY. Subject to the payment of applicable premiums and any applicable Federally Facilitated Marketplace enrollment change application, the following individuals are eligible to enroll in the PPO; provided however, that if the Group has a probationary or waiting period during which an individual may not be eligible to enroll in the PPO, coverage may become effective only after such probationary or waiting period has been satisfied.

6.1 Subscriber. To be eligible to enroll and continue enrollment in the PPO as a Subscriber, a person must be:

a) a Member for whom payment has actually been received by the PPO; and

b) a bona fide (one who may legally work in the United States) employee of a Group or member of a union entitled to participate in a health benefits program arranged by the Group or be entitled to coverage under a trust agreement and have satisfied any probationary or waiting period established by the Group; or

c) a former bona fide employee or member of a union, or the dependent of a former bona fide employee or member of a union, entitled under COBRA or other law, or as otherwise set forth in the Group Master Policy, to participate in a program of health benefits arranged by the Group.

Unless otherwise set forth in the Group Master Policy or as otherwise entitled under COBRA or other law, a retiree of the Group is not eligible to enroll as a Subscriber. No change in the Group's eligibility or participation requirements is effective for purposes of coverage, except with the prior written consent of the PPO.

6.2 Family Dependent. To be eligible to enroll as a Family Dependent, an individual must be either:

a) The spouse of a Subscriber under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania or a Domestic Partner under the terms and conditions of Section 6.2.8 of this Certificate.

b) A Subscriber's child (married or unmarried) who has not yet attained the age of twenty-six (26) is eligible for enrollment. Eligible children include: newborn children, stepchildren, children legally placed for adoption, children awarded coverage pursuant to an order of court, and legally adopted children of the Subscriber or the Subscriber's spouse. Eligibility shall cease for a dependent child on the day prior to the child's 26th birthday.

c) The Subscriber's dependent child (married or unmarried) who is age twenty-six (26) or older, who, (i) as medically certified by a physician, is incapable of self-support due to mental retardation or a physical disability, mental illness or developmental disability and who became so prior to the attainment of age nineteen (19); and (ii) who is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance, may continue enrollment or will become eligible for enrollment under Family Coverage for the duration of such disability and dependency.

Eligibility shall cease for a dependent child on the day prior to the dependent child's 26th birthday (except for disabled dependent children). Coverage for a Family Dependent will

become effective only if the Subscriber has Family Coverage and the applicable premium is duly paid.

6.2.1 **New Spouse.** A newly married Subscriber may arrange for Family Coverage by enrolling his or her spouse in the PPO within thirty-one (31) days of marriage. Coverage of the spouse under this Certificate shall be effective as of the date of marriage if the Subscriber's coverage was in effect on that date. Premiums for such continued coverage of a spouse shall be payable from the date of marriage. No Evidence of Insurability shall be required.

6.2.2 **Newborn Child(ren).**

6.2.2.1 **Coverage from Birth to Thirty-One (31) Days.** A newborn child, whether natural born, adopted, or placed for adoption, of the Subscriber or eligible Family Dependent is covered as a Member under this Certificate from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

6.2.2.2 **Coverage Beyond The First Thirty-One (31) Days.** To continue coverage of a newborn child beyond the first thirty-one (31) days, the criteria in (a) or (b) below must be met on behalf of the newborn:

a) the newborn child must be a child who is a natural born, adopted or legally placed for adoption, or under the Legal Guardianship or Legal Custodianship of the Subscriber or the Subscriber's eligible spouse.

To have the newborn child of the Subscriber or the Subscriber's eligible dependent spouse covered as a Family Dependent under this Certificate beyond the thirty-one (31) day period, the Subscriber must do the following:

i) Contact the Customer Service Team within thirty one (31) days from the newborn's birth: i) at the telephone number on the back of the Identification Card or ii) in writing at the address listed on Page (iii) of this Certificate and inform the Customer Service Team that the newborn will be added to the Certificate.

ii) The Customer Service Team representative will send a "Subscriber Application Change Form" to the Subscriber.

iii) The "Subscriber Application Change Form" must be completed by the Subscriber and returned to the PPO within thirty-one (31) days of the newborn's birth for the newborn to be added to the Certificate.

iv) The Subscriber must also pay any premium payment required for the addition of the newborn to the Certificate.

OR

b) the newborn's parent(s), Legal Guardian, or Legal Custodian may convert to a separate individual policy, offering similar benefits to this Certificate, on behalf of the newborn. Such application shall not be subject to evidence of insurability.

It shall be the responsibility of the newborn's parent(s), Legal Guardian, or Legal Custodian to notify the PPO of this choice within thirty-one (31) days from the newborn's birth.

6.2.2.3 **Coverage During the Transition Period for Legal Guardianship/Custodianship.** Coverage can be secured during the transition period for Legal Guardianship/Custodianship upon submission of proof of application for Legal Guardianship. Premiums for coverage of such child shall be payable from the date of birth. Any Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination.

6.2.3 **Adopted Child.** A legally adopted child or a child for whom a Subscriber or the Subscriber's eligible dependent spouse is a court appointed Legal Guardian or Legal Custodian and who meets the definition of a Family Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a Subscriber's coverage becomes effective and the Subscriber must make a written request for coverage within thirty-one (31) days of the date the child is adopted or placed with the Subscriber or the Subscriber's eligible dependent spouse for adoption.

An adopted child or a child placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse is automatically covered under this Certificate for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from single to Family Coverage) must be submitted to the PPO within thirty-one (31) days of the date of adoption or date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. The PPO will require documentary proof (i.e., official court documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage. No Evidence of Insurability shall be required.

6.2.4 **Children Born To Family Dependents.** A child born to a Family Dependent is automatically covered under this Certificate for thirty-one (31) days from the date of birth. Coverage of such child beyond thirty-one (31) days from the date of birth may continue if the criteria set forth in Section 6.2.2.2 is met. Accordingly, to continue coverage of such child, the Subscriber must submit a request for addition to Family Coverage to the PPO within thirty-one (31) days of the date of birth and pay the required premium. Children born to a Domestic Partner who are not Family Dependents of the Subscriber are not eligible for coverage under this Certificate.

6.2.5 **Continued Coverage of Disabled Dependent Child.** A dependent child (married or unmarried) may continue enrollment under Family Coverage for the duration of such disability and dependency when the following conditions are met:

a) the child exceeds the Maximum Age for dependent children; and

b) the child is incapable of self-sustaining employment by reason of disability resulting from mental retardation or a physical disability which meets the criteria under §88.41 of Title 31, PA Code and the child became so prior to the attainment of age nineteen (19); and

c) the child is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance; and

d) the child must have been enrolled under the terms of another Group health benefit program offered by the PPO or the PPO's affiliate as an alternative to this Group health benefit program.

The PPO may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the PPO is first notified of such disability and dependency, whichever is earlier.

6.2.6 **Military Duty.** For full-time students who are (i) members of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who are called or ordered to active duty, other than active duty for training, for a period of thirty (30) or more consecutive days; or (ii) members of the Pennsylvania National Guard ordered to active state duty, including duty related to the Emergency Management Assistance Compact, for a period of thirty (30) or more consecutive days, the following shall apply:

The eligibility for coverage for full-time students as defined above shall be extended for a period equal to the duration of the student's service on active duty or active state duty or until he or she is no longer a full-time student. The eligibility of a full-time student as defined above shall not terminate because of the age of the eligible student when the student's educational program was interrupted because of military duty.

To qualify for this extension, the full-time student shall:

(i) submit a form approved by the Department of Military and Veterans Affairs notifying the PPO that the full-time student has been placed on active duty;

(ii) submit a form approved by the Department of Military and Veterans Affairs notifying the PPO that the full-time student is no longer on active duty;

(iii) submit a form approved by the Department of Military and Veterans Affairs showing that the full-time student has reenrolled as a full-time student for the first term or semester starting sixty or more days after his or her release from active duty.

A full-time student under this Section shall mean:

(i) A dependent child who is eligible for health insurance coverage under their parents' insurance policy, **and**

(ii) who is either a high school student or enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

The PPO may periodically require documentary proof of enrollment as a student upon reaching the Maximum Age for dependent children set forth on the Schedule of Benefits, or upon the date on which the PPO is first notified of such enrollment.

6.2.7 **Noncustodial Children.** A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order. The Subscriber must make written application for membership of such child. The PPO will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty-one (31) days of receipt by the PPO of said official court order. The Subscriber shall notify the PPO of the name and address of the custodial parent in order to allow the PPO to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania. The PPO may not disenroll or eliminate coverage of any child unless the PPO is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

6.2.8 **Domestic Partner.** A Domestic Partner may be added as a Family Dependent if Domestic Partner meets the terms and conditions of this Section 6.2.8.

6.2.8.1 **Domestic Partner** means an individual who is: (i) eighteen (18) year of age or older and the same sex or opposite sex as the Subscriber; (ii) not related to the Subscriber by marriage or blood in a way that would bar marriage; (iii) involved with the Subscriber in a committed lifetime relationship; and (iv) financially interdependent with the Subscriber for a period of not less than six (6) months.

6.2.8.2 **Domestic Partnership** means the relationship established between a Domestic Partner and a Subscriber whereby the Subscriber has filed a notarized affidavit with the Subscriber's Employer Group, if applicable, and the PPO certifying that the requirements of a Domestic Partner, as defined herein, have been fulfilled.

6.2.8.3 **Enrolling a Domestic Partner.** A Subscriber who: (i) has demonstrated a Domestic Partnership; (ii) has satisfied the eligibility requirements as set forth in this Section 6.2.8, and (iii) is not legally married may arrange for Family Coverage by enrolling his or her Domestic Partner in the PPO during an Open Enrollment Period. The effective date of coverage of the Domestic Partner under the Certificate will be predetermined by the PPO and the Group, if applicable. Premiums for such coverage of a Domestic Partner shall be payable from the date which the Domestic Partner becomes a Family Dependent. No proof of insurability shall be required. The dependents of a Domestic Partner who are not Family Dependents of the Subscriber under this Certificate are not eligible for enrollment.

6.2.8.4 **Loss of Eligibility.** Once enrolled, each Member must continue to meet the applicable eligibility criteria as set forth in this Section 6.2.8. Loss of eligibility, which includes termination of a Domestic Partnership, shall result in termination of coverage effective the day after the date upon which eligibility ceases. The Subscriber shall be responsible to notify the PPO and the Group, if applicable, in writing immediately upon termination of such Domestic Partnership.

6.3 Continued Eligibility During Military Service. If a Subscriber is called to Active Military Duty (for the purpose of this Section only, Active Military Duty is defined as voluntary or involuntary duty in a uniformed service under competent authority), coverage will continue under the PPO for the first thirty (30) days of the Active Military Duty. After the expiration of the first thirty (30) days, the Subscriber will be given the option of continuing health care coverage at their own expense through a COBRA or Mini-COBRA offering, as applicable, for themselves and their eligible Family Dependents. This offering will be at the same rate paid by the employer for the Subscriber's and the Subscriber's eligible Family Dependents' coverage. The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.20 of this Certificate.

For COBRA-eligible Groups of 20 or more Employees, the following Section 6.4 shall apply:

6.4 COBRA. COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time, is a federal law providing continued group coverage to Members who:

a) have ceased eligibility under the terms and conditions of the Certificate due to a qualifying event, as defined under COBRA; and

b) have properly elected to receive COBRA coverage.

If a Member ceases to be eligible for enrollment under this Certificate as a result of a qualifying event, as defined under COBRA, and such Member has properly elected to receive COBRA coverage as set forth in COBRA, then such Member may continue coverage through the Group for up to the maximum period of time set forth under COBRA. Upon timely notice from the Group, the PPO will make continuation coverage available. The Group retains full responsibility for providing to Members all required notices and information relating to COBRA continuation coverage rights, as required by law. The PPO shall have no obligation to notify Members of continuation coverage rights under COBRA. The PPO is not the COBRA administrator. The Member should contact the Group for specific information on how to elect COBRA coverage and the associated costs of such coverage. Premiums for COBRA coverage will be remitted to the PPO by:

a) the Group or its agent within the time frames required under this Certificate or as otherwise set forth in the Group Master Policy on behalf of the Subscriber and/or any Family Dependent(s); or

b) the Subscriber on behalf of himself and/or any Family Dependents.

6.4.1 **Post-COBRA Conversion Coverage**. A Subscriber and/or eligible Family Dependents shall be entitled to obtain a conversion policy upon termination of COBRA coverage according to the terms and conditions set forth in Section 8.6.8 of this Certificate.

For Groups of 2-19 Employees, the following Section 6.5 shall apply:

6.5 Mini-COBRA. Mini-COBRA, as may be amended from time to time, was enacted in 2009 by the Commonwealth of Pennsylvania. It provides COBRA continuation coverage for Subscribers and eligible dependents (eligible dependent means spouse or dependent child of the Subscriber) who:

a) have been continuously insured under the Certificate or insured for similar benefits under any group policy which it replaced, during the entire three (3) month period ending with the Member's termination;

b) have ceased eligibility under the terms and conditions of the Certificate due to the occurrence of a qualifying event as defined under Mini-COBRA;

c) are not covered by or eligible for coverage under Medicare;

d) are not covered or eligible to be covered under any other insured or uninsured group health insurance coverage under which the Member was not covered immediately prior to termination (excludes Medical Assistance, CHIP and adultBasic);

e) can verify he or she is ineligible for employer based group insurance as an eligible dependent; and

f) have properly elected to receive Mini-COBRA coverage.

If a Member ceases to be eligible for enrollment under this Certificate as a result of a qualifying event, as defined under Mini-COBRA, and such Member has properly elected to receive Mini-COBRA coverage as set forth in Mini-COBRA, then such Member may continue coverage through the Group for up to the maximum period of time set forth under Mini-COBRA. Upon timely notice from the Group, the PPO will make continuation coverage available. The Group retains full responsibility for providing to Members all required notices and information relating to Mini-COBRA continuation coverage rights, as required by law. The PPO shall have no obligation to notify Members of continuation coverage rights under Mini-COBRA. The PPO is not the Mini-COBRA administrator. The Member should contact the Group for specific information on how to elect Mini-COBRA coverage and the associated costs of such coverage. Premiums for Mini-COBRA coverage will be remitted to the PPO by:

a) the Group or its agent within the time frames required under this Certificate or as otherwise set forth in the Group Master Policy on behalf of the Subscriber and/or any Family Dependent(s); or

b) the Subscriber on behalf of himself and/or any Family Dependents.

6.5.1 **Mini-COBRA Coverage.** Mini-COBRA coverage shall be the same coverage in effect for the Member at the time of the qualifying event.

6.5.2 **Post Mini-COBRA Conversion Coverage.** A Subscriber and eligible dependents shall be entitled to obtain a conversion policy upon termination of Mini-COBRA coverage according to the terms and conditions set forth in Section 8.6.8 of this Certificate.

6.6 Effective Date(s) of Coverage. Individuals who meet the eligibility requirements under this Certificate must have:

a) submitted a properly completed Enrollment Application listing the Subscriber and all Family Dependents (regardless of whether they will be enrolled) to the Group;

b) enrolled all Family Dependents or declined coverage in writing for any Family Dependents eligible to be enrolled; and

c) paid the applicable monthly premium for coverage under the terms and conditions of this Certificate.

Only a Member for whom the premium is actually received by the PPO shall be entitled to coverage under this Certificate and only for the month for which such premium is received. Coverage shall be effective as set forth on the Group Master Policy.

6.6.1 **Open Enrollment Period Application.** During an Open Enrollment Period, any person who satisfies the eligibility requirements to enroll as a Subscriber or a Family Dependent shall become immediately eligible. When an eligible individual makes written application for membership during the Open Enrollment Period, the effective date of coverage will be predetermined by the PPO and the Group.

6.6.2 **Non-Open Enrollment Period Application.** Any individual who first satisfies the eligibility requirements and who makes written application for membership at a time other than an Open Enrollment Period but within thirty-one (31) days of initially attaining eligibility shall become effective on the first day of the next calendar month following the date on which he first satisfied the eligibility requirements, except for:

a) newly married spouses, newborns, adopted children, children placed for adoption or children born to Family Dependents, whose dates of coverage are established by law; and

b) as otherwise set forth in the Group Master Policy when the Group Master Policy is modified by the Group.

6.7 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the PPO by submitting a completed Enrollment Application on forms provided by the PPO (or provided by the Group if approved by the PPO). No eligible person will be refused enrollment within thirty-one (31) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a Special Enrollment Period. No Evidence of Insurability shall be required. The Group shall comply with the PPO's underwriting requirements.

6.8 Failure to Enroll Or Be Enrolled When Eligible/Special Enrollment Periods. Any eligible individual who fails to enroll or be enrolled during an Open Enrollment Period (Section 6.6.1) or within thirty-one (31) days after first becoming eligible (Section 6.6.2) shall not be permitted to enroll until the next Open Enrollment Period unless they meet the rules for Special Enrollment Periods.

6.8.1 **Special Enrollment Period-Qualifying Events.**

An individual who experiences a qualifying event will be permitted to enroll in the PPO. Enrollment will be permitted if the PPO receives satisfactory evidence that:

a) the individual was actually enrolled for benefits under another group health benefit program at the time he first became eligible for enrollment in the PPO; or

b) the individual declined enrollment, in writing, for himself and any family dependent, stating that the coverage under another group health plan was the reason for declining enrollment; or

c) the individual was enrolled under another group health benefit program during the most recent Open Enrollment Period, if eligible for enrollment in the PPO at that time; or

d) loss of eligibility under the other group health benefit program was as a result of

i) termination of employment,
ii) reduction in the number of hours of employment,
iii) termination of the other program's coverage,
iv) termination of contributions toward the premium made by the Group,
v) death of a spouse, divorce, or legal separation,
vi) expiration of the COBRA or Mini-COBRA continuation of Benefit Period (for COBRA and Mini-COBRA eligible Groups)**,**

vii) no longer working or residing in the service area when the other group health benefit program (such as an HMO) does not provide benefits to an individual who no longer works or resides in the service area, or

viii) meeting or exceeding a lifetime limit on all benefits under the other group health benefit program; or

e) the individual, or his or her dependent, loses minimum essential coverage. Loss of minimum essential coverage shall include those circumstances describer in the Code of Federal Regulations, Title 26, Chapter 54.9801-6(a)(3)(i) through (iii); or

f) the individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption; or

g) the individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status; or

h) the individual's, or his or her dependent's, enrollment or non-enrollment in a qualified health plan ("QHP") is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange (as defined in 45 CFR Section 155.20) or U. S. Department of Health and Human Services ("HHS"), or its instrumentalities as evaluated and determined by the Exchange; or

i) the individual, or his or her dependent, adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; or

j) the individual, or his or her dependent, is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or

k) the individual, or his or her dependent, gains access to new QHPs as a result of a permanent move;

l) the individual who is an Indian/native American, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

m) the individual, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by the HHS, that the individual meets other exceptional circumstances as the Exchange may provide; or

n) it has been determined by the Exchange that the individual, or his or her dependents, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the individual or enrollee; or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards under 45 CFR Section 155, 156, or other applicable Federal or State laws, as determined by the Exchange.); or

o) the individual, or his or her dependent, experiences any other qualifying event as determined by applicable Federally Facilitated Marketplace Exchange laws and regulations;

AND

p) application for enrollment in the PPO is made within thirty-one (31) days from the date of the qualifying event.

6.8.2 **Special Enrollment Period - Medicaid and CHIP Eligibility and Premium Assistance.** An individual may enroll in the PPO at a time other than Open Enrollment if the PPO receives satisfactory evidence that:

a) An individual or dependent who was covered under a state Medicaid or CHIP plan had their coverage terminated as a result of the loss of eligibility for such coverage. Such individual or dependent must request coverage by the PPO not later than sixty (60) days after the termination of coverage under the state Medicaid or CHIP program.

b) An individual or dependent has become eligible for a premium assistance subsidy for the PPO under a state Medicaid or CHIP plan. Such individual or dependent must request coverage under the PPO not later than sixty (60) days after the individual or dependent is determined to be eligible for such assistance.

6.9 Hospitalization on the Effective Date. A Member who is hospitalized prior to the effective date of coverage hereunder is covered for Covered Services as of the effective date of enrollment in the PPO unless they are covered under a continuation of benefits provision through another carrier. Expenses incurred prior to the effective date of enrollment in the PPO are **NOT COVERED**.

6.10 Continued Eligibility. Once enrolled, each Member must continue to meet the applicable eligibility criteria identified in this Certificate and the Group Master Policy to continue as a Member. Loss of eligibility will result in termination of coverage.

6.11 Notice of Ineligibility. It shall be the Subscriber's responsibility to notify the Group or the PPO of any changes which will affect the Subscriber's eligibility or that of a Family Dependent for Covered Services or benefits under this Certificate within thirty-one (31) days of the event.

SECTION 7. PAYMENT PROVISIONS

7. PAYMENT PROVISIONS.

7.1 Payment of Premiums. The monthly premiums for coverage are specified in the Group Master Policy, as amended from time to time. The Group or its agent on behalf of a Subscriber shall make payment of such premium for coverage under this Certificate. Premium shall be remitted on a monthly basis to the PPO within the specified time frames set forth in this Certificate or as otherwise set forth in the Group Master Policy. Only a Member for whom the premium is actually received by the PPO shall be entitled to coverage under this Certificate and only for the month for which such premium is received.

7.2 Adjustment of Premiums. The monthly premiums shall be effective until the renewal date of the Group Master Policy and shall be subject to revision thereafter as of each renewal date of the Group Master Policy, or such other date as the Group and the PPO may specify. The PPO will notify the Group of any adjustment to premium as set forth in the Group Master Policy. Notice of adjustment of a premium, or adjustment of the Subscriber's contribution to the premium as required by the Group, will be provided by the Group to the Subscriber. Premium changes may be subject to review and approval by the Pennsylvania Department of Insurance.

7.3 Time of Payment. In order for benefits to be provided, the premium must be paid on or before the first day of the effective coverage month for each Member under this Certificate or as specified in the Group Master Policy, subject to the grace period provisions specified in this Certificate. The monthly premium must be paid in full on or before the due date indicated on the first premium statement.

7.4 Grace Period. If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within thirty (30) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 8.6 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 8.9. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependent during the grace period.

8. GENERAL PROVISIONS.

8.1 Circumstances Beyond Control. The PPO shall not be in violation of this Certificate if it is prevented from performing any of its obligations hereunder for reasons beyond its control. These may include, but are not limited to, any of the following: acts of God, war, strikes, statutes, rules, regulations or interpretations of statutes and regulations to which the PPO is subject. In the event the Covered Services which the PPO has agreed to provide are substantially interrupted including, but not limited to, the significant partial destruction of the PPO's administrative offices, or a significant partial disability of the Network, pursuant to any such events, the PPO shall make a reasonable effort to arrange for an alternative method of providing care.

8.2 Coordination of Benefits.

8.2.1 **Definitions.** For purposes of this Coordination of Benefits (COB) provision only, the following definitions shall apply:

a) **Program** is any of the following programs of health benefits coverage that provides medical care or treatment benefits or services to their Members:

i) group health benefits coverage, whether insured or uninsured;

ii) coverage under a governmental health benefits program or a program required by law. This does not include a state program under Medicaid (Title XIX, Grants to States for Medical Assistance programs of the United States Social Security Act, as amended from time to time).

The term Program does not include group or group-type hospital benefit programs of one hundred dollars ($100) per day or less and school accident-type coverage.

Each contract or other arrangement for coverage included under the definition of Program is a separate health benefits Program. If a Program has two components of health benefits coverage and COB rules apply only to one of the two components, then each of the components of health benefits coverage is a separate Program.

b) **This Plan** is the portion of this Certificate that provides Covered Services to Members and is subject to this COB provision.

c) **Primary Plan** and **Secondary Plan.** The following Order of Benefit Determination Rules state whether This Plan is Primary or Secondary relative to another Program covering the Member:

i) When This Plan is Primary, its benefits are provided without consideration for the other Program's benefits;

ii) When This Plan is Secondary, its benefits may be reduced and it may recover from the Primary Plan the reasonable cash value of the Covered Services provided by This Plan.

d) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one (1) or more Programs covering the Member for whom the claim is made. The term Allowable Expense does not include coverage for items **NOT COVERED** under this Certificate. When This Plan provides Covered Services,

the reasonable cash value of each service is the Allowable Expense and is considered a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the Member's stay in a private hospital room is Medically Necessary.

e) **Claim Determination Period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

8.2.2 **Applicability.**

a) If the Member is covered by This Plan and another Program, the Order of Benefit Determination Rules described below determine the Primary Plan/Secondary Plan. The benefits of This Plan:

i) shall not be reduced when, under the Order of Benefit Determination Rules, This Plan is Primary, but;

ii) may be reduced or the reasonable cash value of any Covered Service provided by This Plan may be recovered from the Primary Plan when, under the Order of Benefit Determination Rules, another Program is Primary. The above reduction is more fully described below.

8.2.3 **Order of Benefit Determination Rules.**

a) **General.** When a Member receives Covered Services by or through This Plan, or is otherwise entitled to claim benefits from This Plan, and the Covered Services are the basis for a claim under another Program, This Plan is a Secondary Plan which has its benefits determined after those of the other Program, unless: i) the other Program has rules coordinating its benefits with those of This Plan; and ii) both the other Program and This Plan's rules in subparagraph (b) below, require that This Plan's benefits be determined before those of the other Program.

b) **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

1) **Non-Dependent/Dependent.** The benefits of the Program which covers the Member as a Subscriber are Primary to those of the Program which covers the Member as a Family Dependent.

2) **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph (b) (3) below, when This Plan and another Program cover the same child as a Family Dependent of different persons called "parents":

i) the Program of the parent whose birthday falls earlier in a year is Primary to the Program of the parent whose birthday falls later in that year, but;

ii) if both parents have the same birthday, the Program which covered a parent longer is Primary. However, if the other Program does not have the rule described in (i) immediately above, but instead has a rule based on the gender of the parent and if as a result the Programs

do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

3) **Dependent Child/Separated or Divorced Parents.** If two (2) or more Programs cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   i) first, the Program of the parent with custody of the child;

   ii) then, the Program of the spouse of the parent with custody of the child; and

   iii) finally, the Program of the parent not having custody of the child; or

   iv) if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Program obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Program is Primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Program year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4) **Active/Inactive Employee.** A Program which covers a Member as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary to a Program which covers that Member as a laid off or retired employee (or that employee's dependent) and further subject to this Section. If the other Program does not have this rule, and if as a result, the Programs do not agree on the order of benefits, this rule (4) is ignored.

5) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Program which covered a Member longer is Primary to the Program which covered that Member for a shorter time.

8.2.4 **Effect on the Benefits of This Plan.**

a) This Section applies when, under the above Section of the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one (1) or more other Programs. In such event, the benefits of This Plan may be reduced under this Section.

b) **Reduction in This Plan's Benefits.** This Plan may reduce benefits payable or may recover the reasonable cash value of the Covered Services when the sum of the following exceeds those Allowable Expenses in a Claim Determination Period:

   i) the benefits that would be payable for, or the reasonable cash value of the Covered Services under This Plan in the absence of this COB provision; and

   ii) the benefits that would be payable as Allowable Expenses under the other Programs, in the absence of similar provisions like this COB provision, whether or not claim is made.

In such event, the benefits of This Plan will be reduced so that they and the benefits payable under the other Programs do not total more than the Allowable

Expenses. When the benefits of This Plan are reduced as described herein, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

8.2.5 **Right to Receive and Release.** Certain information is needed to apply these COB rules. This Plan has the right to decide which information it needs. This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this. Each person claiming benefits under This Plan must give This Plan any information it needs.

8.2.6 **Facility of Payment.** A payment made or a service provided under another Program may include an amount which should have been paid or provided under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a payment under This Plan.

8.2.7 **Right of Recovery.** If the amount of the payment made by This Plan is more than it should have paid under this COB provision, or if it has provided Covered Services which should have been paid by the Primary Plan, This Plan may recover the excess or the reasonable cash value of the Covered Services as applicable, from one or more of:

a) the persons it has paid or for whom it has paid;

b) insurance companies; or

c) other organizations.

8.2.8 **Provisions of Covered Services.** This Plan shall provide health services first and then seek Coordination of Benefits.

8.2.9 **Medicare and Worker's Compensation.**

8.2.9.1 **Coordination of Benefits with Medicare**. The following Sections set forth whether this PPO is primary or secondary in regard to Medicare coverage for the Subscriber who is age sixty five (65) or older. If the PPO is **primary**, the PPO will pay for Covered Services and Medicare will pay for Medicare eligible expenses, if any, not paid by the Plan. If the PPO is **secondary**, Medicare will pay for Medicare eligible expenses first and the PPO will pay for Covered Services, if any, not paid for by Medicare. For the purpose of this Section, the term Subscriber includes all Family Dependents who are age 65 or older.

a) This PPO is **primary** to Medicare when the Subscriber is age sixty five (65) or older, is Medicare eligible, is defined as an Active Employee by Medicare regulations and is working for an employer with twenty (20) or more employees.

b) This PPO is **primary** to Medicare when the Subscriber is under age sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability (other than ESRD described below) and is an Active Employee (defined by Medicare regulations) working for an employer with at least one hundred (100) employees.

c) This PPO is **secondary** to Medicare when the Subscriber is age sixty five (65) or older, is Medicare eligible and is working for an employer with less than twenty (20) employees.

d) This PPO is **secondary** to Medicare when the Subscriber is age sixty five (65) or older, is retired and is covered with retiree group coverage under the PPO.

e) This PPO is **secondary** to Medicare when the Subscriber is under the age of sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability, is an Active Employee (defined by Medicare regulations) and works for an employer with less than one hundred (100) employees.

f) If the Subscriber has End Stage Renal Disease (ESRD) the PPO will be primary for the first thirty (30) months of the Subscriber's entitlement to Medicare (as defined by Medicare regulations). After the first thirty (30) months, Medicare will become the primary coverage. However, if the PPO is currently providing benefits as the secondary provider when the Subscriber becomes entitled to ESRD Medicare benefits, the PPO will remain the secondary provider. The same conditions apply as indicated above in regard to ESRD if the Subscriber has COBRA coverage under the PPO.

The Subscriber is strongly encouraged to refer to Medicare regulations in regard to the specific requirements for Medicare entitlement.

8.2.9.2 **Double Coverage.** The benefits provided under this Certificate are not designed to duplicate any benefits for which a Member may be eligible under the terms of Medicare, any government-sponsored health benefits program or any applicable Worker's Compensation Law. Benefits hereunder will be reduced to the extent that benefits are eligible for payment regardless of whether the Member has enrolled for participation under Medicare or any government-sponsored health benefits program. Benefits also will be reduced to the extent that benefits are received by the Member under any form of Worker's Compensation coverage. In the event a Member fails to receive benefits for which he is otherwise eligible under the terms of Medicare, any government-sponsored health benefits program or Worker's Compensation because of the failure of the Member to apply for or maintain Medicare or any government-sponsored health benefits program coverage, or to submit required claim documentation or other required documentation, benefits under this Certificate will be reduced by the amount of benefits which the Member would otherwise have received under Medicare, any government-sponsored health benefits program or Worker's Compensation. **If the Member enters into an agreement to settle the Worker's Compensation claim, any future expenses for Covered Services rendered for the injury compensated by the settlement are NOT COVERED.**

8.3 Subrogation. The PPO has the right of subrogation to the extent permitted by the law against third parties that are legally liable for the expenses paid by the PPO under this

Certificate. The Member shall do nothing to prejudice the subrogation rights of the PPO. The PPO may recover benefits amounts paid under this Certificate under the right of subrogation to the extent permitted by law.

TERM AND TERMINATION.

8.4 Term. The effective date of this Certificate is stated on the Schedule of Benefits. The initial term of this Certificate commences on such effective date and continues until the renewal date of the Group Master Policy. This Certificate shall automatically be renewed thereafter from year-to-year, unless sooner terminated as set forth below in Section 8.6.

8.5 Termination by the Group. The Group may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Group shall result in the individual rights to benefits and Covered Services awarded under this Certificate ceasing on the effective date of termination, except as set forth in Section 8.9.

8.6 Termination by the PPO. The PPO may terminate this Certificate for the following reasons:

8.6.1 **Failure to Pay.**

8.6.1.1 **By the Subscriber.** In the event any Subscriber fails to pay any premium amount due the PPO, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the PPO to the Group and to the Subscriber. A Member whose coverage is terminated under this Section for failure to pay may not reapply for a period of eighteen (18) months following such termination.

8.6.1.2 **By the Group.** In the event the Group fails to pay any amount due the PPO, for the benefit of the Subscriber or any Family Dependents, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the PPO to the Group and to the Subscriber. A Member whose coverage is terminated due to the Group's failure to pay pursuant to this Section may be eligible for conversion to individual, direct payment coverage without Evidence of Insurability, provided that application is made within thirty-one (31) days of the date of notification of termination and subject to payment of premiums as billed within thirty-one (31) days of the date such bill is issued. If the Member fails to reapply with the PPO for conversion coverage within thirty-one (31) days of the termination notification date, the Member upon future application to the PPO, will need to provide evidence of insurability as part of the application process.

8.6.2 **Fraud or Material Misrepresentation.**

8.6.2.1 **By the Group.** In the event the Group makes an intentional misrepresentation of a material fact for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. This decision may be appealed through the PPO's established appeal procedure as set forth in Section 5 of this Certificate.

8.6.2.2 **By the Member.** If it is proven that the Member attempted or committed fraud under this Certificate to obtain benefits or payment or if the Member makes an intentional misrepresentation of material fact in the application for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber and the Group. This decision may be appealed through the PPO's established appeal procedure as set forth in Section 5 of this Certificate.

8.6.2.3 **Misrepresentation Regarding Tobacco Use.** If a Member makes an intentional misrepresentation of a material fact regarding the use of tobacco on the Application and is later found to be using tobacco, the misrepresentation may result in the Member being charged the rate applicable if the tobacco use had been disclosed at the beginning of the Certificate Enrollment Date.

A Member whose coverage is terminated under this Section for fraud or intentional misrepresentation of a material fact may not apply to the PPO for health coverage for a period of thirty-six (36) months following such termination.

8.6.3 **Failure to Continue to Meet the Group Eligibility Requirements.** If a Member ceases to meet the Group eligibility requirements, coverage shall terminate subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber.

8.6.4 **Termination of Group Master Policy.** The PPO may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the PPO means that individual rights to benefits and Covered Services awarded under this Certificate cease on the effective date of termination. If a Member whose coverage was terminated pursuant to this Section has succeeding or alternate carrier health service coverage, they are not eligible for conversion to individual, direct payment coverage where there is a succeeding or alternate carrier. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 8.9 of this Certificate.

8.6.5 **Subscriber's Death.** In the event of the death of a Subscriber, coverage shall terminate for his enrolled Family Dependents on the last day of the period for which payments have been made by, or on behalf of such Subscriber, subject to the conversion privilege set forth below. Surviving Family Dependents may also be eligible to continue Group coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 8.9.

8.6.6 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage with respect to the child subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber. This decision may be appealed through the PPO established appeal procedure as set forth in Section 5 of this Certificate.

8.6.7 **Disruptive Behavior.** The PPO may terminate a Member's coverage for cause if the Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his continuing membership in the PPO seriously impairs the PPO's ability to provide Covered Services to either that Member or to other Members. Termination will occur

after the PPO has made a reasonable effort to resolve the problem presented by the Member, including encouraging the Member to utilize the PPO's internal appeal procedure as set forth in Section 5 of this Certificate.

8.6.8 **Conversion Privileges.** If a Member's coverage terminates for any reason other than non-payment of a required contribution and the Member has been continuously insured under the Certificate for at least three (3) months immediately prior to termination, the Member shall be eligible for individual conversion coverage (referred to as "Conversion Coverage").

A Member is not entitled to Conversion Coverage if other similar group coverage will replace this Certificate within thirty-one (31) days, or if coverage terminated under the Certificate because the Member failed to pay required premium contributions. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA and Mini-COBRA eligible Groups) are eligible for conversion coverage when their COBRA or Mini-COBRA eligibility for Group coverage expires.

The PPO will give the Member written notice of the conversion privilege within fifteen (15) days before or after the date of termination of coverage. The Member must apply for Conversion Coverage and pay the applicable premiums within thirty-one (31) days after the termination of coverage under the Certificate, or within fifteen (15) days after the PPO provides the Member notice of conversion rights, whichever is later.

The Member may enroll in Conversion Coverage without a medical examination. The first premium payment must be received before Conversion Coverage will be put in force. Conversion Coverage shall begin the day after termination of coverage under the Certificate.

8.7 Reinstatement.

8.7.1 The PPO shall automatically reinstate a Member whose coverage has been terminated due to a clerical error on behalf of the PPO, when the PPO becomes aware of any clerical error. Premiums shall be payable from the effective date of reinstatement.

8.7.2 At its sole discretion, the PPO may reinstate a Member whose coverage has been terminated:

a) for loss of eligibility, if the Member recaptures eligibility status and continues to satisfy the eligibility requirements; or

b) at the Subscriber's request, if the Subscriber or the Group notifies the PPO within thirty-one (31) days of the date of the initial request to terminate that termination is no longer desired.

8.8 Refunds. When a Member's coverage is terminated, any periodic payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded or credited to the Group. Neither the PPO nor Preferred Providers shall have any further liability under this Certificate, except as set forth in Section 8.9.

8.9 Continuation of Benefits. If a Member is an inpatient in a hospital or skilled nursing facility on the effective date of termination, the benefits for inpatient Covered Services shall be provided:

1) until the inpatient stay ends; or
2) until any applicable Benefit Limit has been reached; or
3) until the Member becomes covered without limitation as to the condition for which he or she is receiving inpatient care under any other group coverage; or
4) up to the end of the Benefit Period;

whichever comes first.

In the event of coverage terminates because of active employment termination, the Covered Services will be provided during for twelve (12) months during total disability with respect to the sickness or injury which caused the disability unless coverage is afforded for total disability under another group plan.

8.10 Health Status. Members enrolled under this Certificate will not have coverage terminated because of health status or requirements for health services.

MISCELLANEOUS.

8.11 Disclaimer of Liability. It is expressly understood that the PPO (as a corporation or otherwise) does not furnish any health service benefits. The PPO contracts with professional providers of care for the Covered Services received by Members under this Certificate. The PPO's obligation is limited to furnishing Covered Services through contracts with such providers of care. The PPO (as a corporation or otherwise) is not, in any event, liable for any act or omission of the professional personnel of any medical group, hospital, or other provider of services.

8.12 Designation of an Authorized Representative. Members have the right to designate an authorized representative who, in addition to the Member receiving services, will receive Explanation of Benefits forms from the PPO. If a Member wishes to designate an authorized representative, they must complete and sign an Authorized Representative form. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member Identification Card.

8.13 Refusal to Accept Recommended Treatment and Advance Health Care Directives. A Member has the right to participate in planning his own treatment and to give his informed consent before the start of any procedure or treatment. A Member also has the right to formulate an Advance Health Care Directive and/or appoint a surrogate to make health care decisions on his behalf to the extent permitted by law, should the Member become incapacitated. Any Member may, for personal reasons, refuse to accept one or more drugs, treatments or procedures recommended by a Preferred Provider. A Member has the option to refuse to accept the recommended drug, treatment or procedure of a Preferred Provider, either:

a) verbally;

b) through an Advanced Health Care Directive; or

c) through a properly appointed surrogate.

8.14 Claims and Reimbursement.

8.14.1 **Claims.** The PPO will not be liable under this Certificate unless proper notice is furnished to the PPO that Covered Services have been rendered to a Member as follows:

a.) **Preferred Provider Claims.** The timely filing of claims is the responsibility of the Preferred Provider, and the Member will have no payment responsibility for such claim which is not filed on a timely basis by the Preferred Provider.

b.) **Non-Preferred Provider Claims.** Members are required to file a claim for all services rendered by a Non-Preferred Provider. No payment will be made for any claims filed by a Member for services rendered by a Non-Preferred Provider unless the Member gives written notice of such claim to the PPO within one (1) year of the date of service.

To file a claim, the Member should call the PPO at the telephone number listed on the Member Identification Card to obtain a claim form. Section A of the claim form must be signed by the Member before the PPO will issue payment to a provider or reimburse the Member for services received under this Certificate. The Member must complete a claim form for services rendered by a Non-Preferred Provider and submit it, together with an itemized bill, to the following address:

Geisinger Quality Options, Inc.
P.O. Box 8200
Danville, PA 17821-8200

If a claim form is not received by the Member within fifteen (15) days of request to the PPO, the Member may provide an itemized bill from the Provider containing the following information, in writing, in lieu of the claim form:

1.) Full name of Member for whom the services were rendered.
2.) Date(s) of service.
3.) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
    a. Procedure/Service codes (and Modifiers)
    b. Diagnosis codes
    c. Location code
4.) Charges for each service.
5.) Servicing Provider/facility and address. If available, telephone number and Provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Quality Options, Inc.
P.O. Box 8200
Danville, PA 17821-8200

Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof of loss is otherwise required.

8.14.2 **Reimbursement.** In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered

Services are rendered, the PPO will reimburse the Member by check immediately upon receipt of written proof of claim set forth under Section 8.14.1 of this Certificate. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the PPO as soon as possible, but in no event later than one (1) year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

8.15 Amendments. The provisions of this Certificate cannot be altered or changed by any representative or agent of the PPO, other than by a written Amendment or Rider signed by the President or other authorized officer of the PPO.

8.16 Authorization to Disclose Confidential Information. Subject to the medical records confidentiality provisions below, the PPO is entitled to receive from any provider of Covered Services to any Member, information reasonably necessary in connection with the administration of this Certificate.

8.16.1 **Medical Records-Confidentiality.** A Member's medical record and other information, including information relating to HIV/AIDS, Substance Abuse and behavioral health treatments, received by the PPO concerning Members will be kept confidential to the extent required by law. Such records and other information will be disclosed by the PPO only as required by law or court order, upon written authorization by a Member, or in connection with: verification of a Member's coverage, including coordination of benefits, facilitation of claims payment, and care coordination; exchange of information between the PPO and its agents/contractors and other Providers for bona fide medical purposes or in connection with a Member's appeal; compilation of demographic data; internal and external audits; the conduct of the PPO quality improvement and medical management programs; and general administration of this Certificate and the PPO.

8.16.1.1 **Cost of Medical Records.** The cost of providing medical records to the PPO or a Preferred Provider is a covered benefit if the Covered Services received by the Member are Medically Necessary and provided through a Preferred Provider or upon Precertification by the PPO.

8.17 Modifications. Through the Group Master Policy, the Group makes coverage under this Certificate available to persons who are eligible. However, the Group Master Policy and this Certificate shall be subject to amendment, modification or termination in accordance with any provision thereof or hereof without the consent or concurrence of or notice to the Members, except as provided for herein. By electing coverage pursuant to this Certificate or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, amendments and provisions thereof and hereof. Disclosure of information regarding a change to benefits shall be provided to Members within thirty (30) days of the effective date of the change.

8.18 Enrollment Applications and Statements. Members or applicants for membership shall complete and submit to the PPO such Enrollment Applications, or other forms or statements as the PPO may reasonably request. Members and applicants for membership represent that all information contained in such Enrollment Applications, forms or statements submitted to the PPO prior to enrollment under this Certificate or the administration hereof shall be true, correct and complete to the best of their knowledge or belief, and all rights to benefits

hereunder are subject to the condition that such information shall be true, correct and complete.

8.19 Computation of Time. Unless otherwise specifically stated, all references in this Certificate to "day" shall mean calendar day. All references to "effective date" shall mean 12:01 a.m. of such calendar date determined on the basis of the location of the PPO's address.

8.20 Clerical Error. Clerical error, whether of the Group or the PPO, in keeping any record pertaining to the coverage under this Certificate will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

8.21 Gender. All pronouns used herein shall include both the masculine and the feminine gender, as the context requires.

8.22 Notices. Any notice under this Certificate may be given by United States Mail, first class, postage prepaid, addressed as follows:

Geisinger Quality Options, Inc.
M.C. 3220
100 North Academy Avenue
Danville, PA 17822
Attention: Administration

Claims and requests for reimbursement should be sent to the attention of the "Claims Department." Notice to a Member will be sent to the Member's last address known to the PPO.

8.23 Substitution of Non-Covered Services. Other provisions of this Certificate notwithstanding, the PPO reserves the right to provide any service, supply, equipment or benefit which is otherwise **NOT COVERED**, or which is limited or excluded, when, in the sole judgment of the PPO, provision of such service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equivalent benefits available under this Certificate and the Member and his or her attending physician accept such service. Any such substitution shall be subject to such quality assurance standards as the Pennsylvania Department of Health may establish. The Member has the ability to return to the benefits of the Certificate at any time.

8.24 Time Limit on Certain Defenses.

8.24.1 **Material Misstatements**. Material misstatements made by the applicant in connection with the Certificate will, at the option of the PPO, permit the PPO to void the Certificate or deny claims, provided such material misstatement is discovered by the PPO within three (3) years of the date of issue of the Certificate.

8.24.2 **Intentional Misrepresentation of a Material Fact.** Intentional misrepresentation of a material fact made by the applicant in connection with the Certificate will, at the option of the PPO, render the Certificate void from inception, provided such intentional misrepresentation of a material fact is discovered by the PPO within three (3) years of the date of issue of the Certificate.

8.25 Legal Actions. The Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted, if the Member is a member of an ERISA group. No such action shall

be brought after the expiration of three (3) years after the time written proof of claims for Covered Services is required to be furnished.

8.26 Physical Examination. The PPO, at its own expense, shall have the right and the opportunity to request a physical examination of the Member upon reasonable notice to determine the validity of a claim.

8.27 Discretionary Authority. The PPO has the full discretionary authority to make benefit and eligibility determinations and adjudicate claims under the Group's health benefit plan.

8.28 Compliance with the Law; Amendment. Anything contained herein to the contrary notwithstanding, the PPO shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Certificate, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Certificate for any one (1) or more eligible Members enrolled under this PPO, and each party hereby agrees to any amendment of this Certificate which is necessary in order to accomplish such purpose, provided that the changes described in such Amendment are made on a uniform basis consistent with the provisions of HIPAA.

8.29 Governing Law. This Certificate is subject to the laws of the Commonwealth of Pennsylvania and applicable Federal law. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Policy shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

8.30 Fraud and Abuse. There may be times when a Member needs to report fraud or abuse they have observed. This could be fraud and abuse by a Member or a Provider. Health care fraud is an intentional misrepresentation, deception, or intentional act of deceit for the purpose of receiving greater reimbursement. Abuse is reckless disregard or conduct that goes against and is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement.

To report suspected fraud or abuse, a Member can call the PPO's fraud and abuse hotline at **1-800-292-1627**. The Member does not have to give their name if they call the hotline, but if they do, it will be kept confidential. The hotline is available 24 hours, seven (7) days a week.

Examples of fraud and abuse are:

Examples of Fraud

- Submitting claims for services not provided or used.
- Falsifying claims or medical records.
- Misrepresenting dates, frequency, duration or description of services rendered.
- Billing for services at a higher level than provided or necessary.
- Falsifying eligibility.
- Failing to disclose coverage under other health insurance.

Examples of Abuse

- A pattern of waiving Cost Sharing.
- Failure to maintain adequate medical or financial records.
- A pattern of claims for services not medically necessary.

- Refusal to furnish or allow access to medical records.
- Improper billing practices.

8.31 Headings. The headings of sections and paragraphs contained in this Certificate are for reference purposes only and shall not affect in any way the meaning or interpretation of the Certificate.

EXHIBIT 1
GEISINGER CHOICE PPO WITH NO REFERRAL
SERVICE AREA

SERVICE AREA shall mean the following counties located in Pennsylvania: Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Elk, Fulton, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York.

(In Bedford and Elk Counties, only areas within the listed U.S. Postal Service zip codes identified below are included):

BEDFORD COUNTY
- the following zip codes only:
15521
15554
16614
16633
16650
16655
16659
16664
16667
16670
16672
16678
16679
16695

ELK COUNTY
- the following zip codes only:
15821
15822
15823
15827
15831
15841
15846
15860
15868

Exhibit 2
Non-Preferred Provider Cost Sharing Example Chart

As described in Section 1.37, when using a Non-Preferred Provider, any costs that exceed the PPO's Non-Preferred Provider Fee Schedule Amount are not included in the Maximum Out-of-Pocket. This means that the Member will be financially responsible for the difference between the PPO's Non-Preferred Provider Fee Schedule Amount and the Non-Preferred Provider's billed charge, even if the Maximum Out-of-Pocket has been reached. This could result in significant financial liability for the Member.

The following example illustrates the concept outlined above:

		Member Owes	**PPO Pays**
Provider's Charges	$10,000		
PPO Allowed Amount	$3,000	$7,000 (Provider charges, less PPO allowed amount)	
Deductible	$250	$250	
Coinsurance ($2,750 at 10%)	10%	$275	
PPO Payment ($3,000 - $250 - $275)			$2,475
Total		$7,525	$2,475

NOTE: The figures in this example are for illustration purposes only. Refer to the Schedule of Benefits for the specific Deductible, Coinsurance and/or Copayment amounts which are applicable to this Certificate.

Exhibit 3
Precertification List

The following (A) services and/or supplies or (B) agents and/or medications require Precertification as described in Section 2 of the Certificate.

Please note those items with an asterisk (*) are not covered when provided by Non-Preferred Providers.

A. Services and/or supplies:

1. Advanced Molecular Topographic Genotyping *
2. Autologous Chondrocyte Implantation
3. Bioengineered Skin Equivalents (including, but not limited to, Dermagraft TM , Allograft TM, and Apligraf TM (Graftskin) – a type of skin graft)
4. Blepharoplasty (plastic surgery of the eyelids)
5. Breast Reduction/Reconstruction-unrelated to previous mastectomy for Breast Cancer
6. Cochlear Implants (surgically implanted hearing device)
7. Comparative Genomic Hybridization (CGH) or Chromosomal Microarray Analysis (CMA) for Evaluation of Developmental Delay*
8. Deep Brain Stimulation
9. Durable Medical Equipment (DME)*
10. Dorsal Column Stimulation (spinal column stimulation)
11. Electrical Stimulation to aid bone healing; invasive procedure (surgical procedure related to bone growth stimulator)
12. Extracorporeal Shock Wave Treatment (ESWT) for Musculoskeletal Indications
13. Extraction of Teeth and Alveoloplasty (limited to extractions performed by an oral surgeon that are required prior to organ transplantation, cardiac or radiation procedures)
14. Fetal Surgery (surgery on the unborn child)
15. Gastric Electrical Stimulation
16. Gene Expression Profiling for Breast Cancer (Oncotype DX)*
17. Gene Expression Profiling for Colon Cancer (Oncotype DX)*
18. Genetic Testing for BRCA1 or BRCA2 for Breast or Ovarian Cancer*
19. Genetic Testing Related to Colorectal Cancer*
20. Health Care Services Associated with Non-Covered Services (such as anesthesia related services to noncovered dental extractions)
21. Home Health Services (including home infusion services)
22. Hospice
23. Injection Therapy for Back Pain*
24. Inpatient Facility Admission
25. Non-Emergency Outpatient Radiology (CT, Echocardiography, MRI, MRA, PET, Nuclear Cardiology, SPECT, Virtual Colonoscopy)
26. Orthognathic Surgery (including, but not limited to mandibular and maxillary osteotomies)
27. Osseointegrated Hearing Device (BAHA Hearing Device)
28. Outpatient Professional Mental Health and Outpatient Professional Substance Abuse Services
29. Outpatient Rehabilitation Services (occupational, physical or speech therapy)
30. Pectus Excavatum or Carinatum (surgical correction of chest deformity)
31. Proton Beam Radiation
32. Restorative or Reconstructive Surgical Procedures (except for a Medically Necessary mastectomy as set forth in Section 3.18 of this Certificate which is not subject to Precertification)
33. Rhinoplasty as stand-alone procedure or Rhinoplasty with or without septal repair, in conjunction with other planned Medically Necessary surgeries
34. Sacral Nerve Stimulation (treatment to improve bladder control)

35. Selective Internal Radiation Therapy
36. Septoplasty as stand-alone procedure/Septoplasty in conjunction with other planned Medically Necessary surgery
37. Skilled Nursing Facility Admission
38. Stereotactic Radiosurgery (including but not limited to Cyberknife, GammaKnife, LINAC, Neuromate, Nerhkoordinaten Manipulator (MKM)
39. Transmyocardial Laser Revascularization (TMLR) (when performed as a stand-alone procedure– process to increase blood supply to the heart)
40. Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells. NOTE: Inpatient hospitalization for transplant services may not be obtained from Non-Preferred Providers.*
41. Vagal Nerve Stimulation (electrical stimulation for seizure control)
42. Varicose Vein Procedures (including injection of sclerosing solution into varicose leg veins and vein stripping)
43. Ventricular Assist Device (VAD)

B. <u>Agents and/or Medications:</u>

1. Abraxane™ (paclitaxel protein-bound particles)
2. Actemra™ (tocilizumab)
3. Aldurazyme™ (laronidase)
4. Aloxi™ (palonosetron)
5. Amevive™ (alefacept)
6. Aralast™ (human alpha$_1$-proteinase inhibitor)
7. Aranesp™ (darbepoetin alfa)
8. Arranon™ (nelarabine)
9. Arzerra™ (ofatumumab)
10. Avastin™ (bevacizumab)
11. Benlysta™ (belimumab)
12. Berinert™ (C1 esterase inhibitor)
13. Bexxar™ (tositumomab and iodine 131 tositumomab)
14. Botox™ (botulinum toxin A and B)
15. Cerezyme™ (imiglucerase)
16. Cimzia™ (certolizumab pegol)
17. Cinryze™ (C1 esterase inhibitor)
18. Clolar™ (clofarabine)
19. Dacogen™ (decitabine)
20. Elaprase™ (idursulfase)
21. Elitek™ (rasburicase)
22. Eloxatin™ (oxaliplatin)
23. Epogen™ (epoetin alfa)
24. Eraxis™ (anidulafungin)
25. Erbitux™ (cetuximab)
26. Erythropoietin Stimulating Agents

27. Fabrazyme ™ (agalsidase beta)
28. Flolan ™ (epoprostenol)
29. Glassia ™ (human alpha$_1$-proteinase inhibitor)
30. Halaven-T ™ (eribulin mesylate)
31. Hyalgan ™(hyaluronate sodium)
32. Ilaris™ (canakinumab)
33. Intravenous (IV) Boniva (ibandronate sodium)
34. Intravenous Immune Globulin (IVIG)
35. Istodax™ (romidepsin)
36. Ixempra ™ (ixabepilone)
37. Jevtana™ (cabazitaxel)
38. Kalbitor™ (ecallantide)
39. Leukine ™ (sargramostim)
40. Lumizyme™ (alglucosidase alfa)
41. Myozyme ™ (alglucosidase alfa)
42. Naglazyme ™ (galsulfase)
43. Neulasta ™ (pegfilgrastim)
44. Neupogen ™ (filgrastim)
45. Nplate ™ (romiplostim)
46. Nulojix ™(belatacept)
47. Off Label Drug Use for Oncologic Indications
48. Ontak ™ (denileukin diftitox)
49. Orencia ™ (abatacept)
50. Orthovisc ™ (hyaluronate sodium)
51. Prialt ™ (ziconotide intrathecal infusion)
52. Procrit ™ (epoetin alfa)
53. Prolastin ™(human alpha$_1$-proteinase inhibitor)
54. Prolia™ (denosumab)
55. Provenge™ (sipuleucel-T)
56. Remicade™ (infliximab)
57. Remodulin ™ (treprostinil)
58. Rituxan ™ (rituximab)
59. Soliris ™ (eculizumab)
60. Stelara™ (ustekinumab)
61. Supartz ™(hyaluronate sodium)
62. Supprelin ™ LA (histrelin acetate implant)
63. Synagis ™ (palivizumab)
64. Torisel™ (temsirolimus)
65. Treanda ™ (bendamustine)
66. Tysabri ™ (natalizumab)

67. Vectibix ™ (panitumumab)
68. Velcade ™ (bortezomib)
69. Veletri ™ (epoprostenol)
70. Viscosupplementation
71. Vitrasert ™ (ganciclovir intravitreal implant)
72. Vivitrol ™ (naltrexone microspheres)
73. White Blood Cell Stimulating Factors
74. Xgeva ™ (denosumab)
75. Xiaflex™ (collagenase clostridium histolyticum)
76. Xolair ™ (omalizumab)
77. Yervoy ™ (ipilimumab)
78. Zemaira ™(human $alpha_1$-proteinase inhibitor)
79. Zevalin ™ (ibritumobab tiuxetan)

Please note those items with an asterisk (*) are not covered when provided by Non-Preferred Providers.

Exhibit 4
Preventive Services

The following preventive health care Covered Services are covered under this PPO with no Cost Sharing (except for Multi Source Brand name drugs and devices as set forth in this Exhibit in Section 10 (a) (ii)) when obtained from a Preferred Provider. Preventive services listed in Exhibit 4 obtained from a Non-Preferred Provider are not covered.

The preventive Covered Services set forth in this Exhibit are subject to change upon revision of the services by the United States Preventive Services Task Force, Centers for Disease Control and Prevention (CDC) (Immunization Practices), the Health Resources and Services Administration (HRSA) and the Institute of Medicine (IOM). For the most current list of preventive Covered Services please refer to: https://www.healthcare.gov/what-are-my-preventive-care-benefits. Please NOTE: Some recommendations may have a future effective date and may therefore not be covered at no Cost Sharing until Benefit Periods beginning on or after that date.

1. **Periodic health assessments** including:

a) medical history;

b) basic ear screening examinations to determine the need for further hearing evaluation and basic eye screening examinations to determine the need for further vision evaluation;

c) for women, chlamydia screening (limited to women ages 16 – 25), gonorrhea screening and a screening Pap smear in accordance with the recommendations of the American College of Obstetrics and Gynecology; and an annual gynecological examination, including a pelvic examination and a clinical breast examination;

d) annual mammogram for women forty (40) years of age and older or any mammogram based on the Provider's recommendation for women under forty (40) years or age (see **NOTE** below);

e) screening for osteoporosis, which may include but is not limited to a DEXA scan (X-ray imaging test which measures bone density for osteoporosis); and

f) cholesterol screening and lipid panel;

NOTE: Benefits for mammography screening are payable only if performed by a mammography service Health Care Provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

2. **Well-child and/or pediatric care** which includes:

2.1 **pediatric and/or well-child care** including:

a) *iron supplementation for children aged 6 through 12 months who are at increased risk for iron deficiency anemia (only iron supplements are covered, multi-vitamins are not covered);

b) *oral fluoride supplementation for children between 6 months of age and age 6 as necessary;

c) medical history;

d) measurements including: height, weight, head circumference, body mass index and blood pressure;

e) sensory screening, which includes:

i) visual acuity screening and basic eye screening examinations to determine the need for further vision evaluation;

ii) basic hearing screening examinations to determine the need for further hearing evaluation;

f) developmental screening and surveillance;

g) autism screening;

h) psychosocial/behavioral assessment;

i) alcohol and drug use assessment;

j) physical examination;

k) lead screening;

l) tuberculin test;

m) dyslipidemia screening;

n) sexually transmitted infection screening; and

o) cervical dysplasia screening.

2.2 **Newborn preventive services** which include:

a) one (1) hematocrit and one (1) hemoglobin screening for infants under twenty-four (24) months;

b) prophylactic eye medication for gonorrhea;

c) hearing loss screening;

d) congenital hypothyroidism screening;

e) phenylketonuria PKU screening; and

f) National Newborn Inheritable Disease Screening Panels as recommended by the HHS Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC).

3. **Immunizations,** in accordance with accepted medical practices excluding immunizations necessary for international travel. Coverage shall be included for immunizations, including the immunizing agents as may be determined by the Pennsylvania Department of Health, the

Patient Protection and Affordable Care Act (PPACA), applicable state and federal regulations and/or the PPO.

4. **Diabetes Care** which includes HbA1c, LDL-C and nephropathy screening tests.

5. **Screening Services** which include:

a) **Colorectal screening** which includes fecal occult blood testing, flexible sigmoidoscopy and colonoscopy procedures.

b) **Abdominal aortic aneurysm screening** for Members aged 65 and older with a history of smoking and/or family history of abdominal aortic aneurysm.

c) **Alcohol screening & counseling.**

d) **Blood pressure screening** for adults age 18 and older.

e) **Depression screening** for adults and adolescents ages 12 through 18.

f) **Human immunodeficiency virus (HIV) Annual Screening** for adolescents and adults**.**

g) **Obesity screening/counseling** for adults and children age 6 and older.

h) **Syphilis screening** as determined by the Provider.

i) **Diabetes screening** of asymptomatic adults who meet criteria for increased diabetes risk as determined by the U.S. Preventive Services Task Force (USPSTF) and/or the PPACA.

j) **Human papillomavirus (HPV) testing.** Women age 30 and over are covered for high-risk human papillomavirus (HPV) DNA testing, regardless of pap-smear results. Testing is limited to one every three years.

k) **Screening and counseling for interpersonal and domestic violence.** Annual screening and counseling for interpersonal and domestic violence is covered for female Members.

6. **Pregnancy related Preventive Services which include:**

a) **Bacteruria screening** for pregnant women in the 12^{th} through 16^{th} week of gestation or during the first prenatal visit, if such a visit is later than the 12^{th} – 16^{th} week period.

b) **Iron deficiency anemia screening** in asymptomatic pregnant women.

c) **Rh (D) blood typing and antibody testing** for all pregnant women during the first prenatal visit and a repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks of gestation, as required.

d) **Syphilis screening** for all pregnant women.

e) **Interventions to support breast feeding** during and after birth.

f) **Tobacco use counseling.**

g) **Hepatitis B virus (HBV) screening** for pregnant women.

h) **Screening for gestational diabetes** is covered for pregnant women between 24 and 28 weeks of pregnancy and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

i) **Breastfeeding support, supplies, and counseling**. Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, and the costs for renting breastfeeding equipment are covered. These services are available for every birth a female Member has while covered under the PPO.

7. **Counseling Preventive Services which include:**

a) **Counseling related to BRCA screening of women** is covered when the woman is referred for such screening or pre-screening evaluation.

b) **Counseling regarding chemoprevention of breast cancer** to inform Members of the potential benefits and harms of chemoprevention of breast cancer as necessary.

c) **Counseling for a healthy diet.** Behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease is covered.

d) **Counseling for sexually transmitted infections.** Annual counseling is covered for sexually active adolescents and adults.

e) **Tobacco use counseling** which includes cessation interventions for those using tobacco.

f) **Counseling for human immune-deficiency virus (HIV)**. Annual Counseling is covered for human immune-deficiency virus (HIV) infection for all sexually active women.

8. **Over-the-counter preventive medications when ordered by a Healthcare Provider.** Such over - the - counter medications include:

a) ***Folic Acid** (containing 0.4 to 0.8 mg) as a daily supplement for women planning or capable of pregnancy.

b) ***Low dose Aspirin to aid in the prevention of Cardio Vascular Disease** (at 81.0 mg strength only) is covered for men and women ages 45 to 79..

*A written or oral prescription for the above *indicated medications must be provided by a Preferred Provider and presented to a Preferred Pharmacy or Preferred Mail Order Pharmacy for coverage by the PPO.

9. **Well-woman preventive care visits** annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

10. **Female Contraceptive methods and counseling.** All Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered as prescribed by the Member's Preferred Provider.

a) **Contraceptive prescription drugs and devices.** Contraceptive prescription drugs and devices are covered subject to the Cost Sharing set forth below.

i. **Single Source Brand Name Drugs and Devices** (brand name drugs/devices without a generic equivalent) and generic drugs/devices are covered with no Member Cost Sharing.

ii. **Multi Source Brand Name Drugs and Devices** (brand name drugs/devices with a generic equivalent) are covered as per the Member's Prescription Drug Rider or, for Members with no Prescription Drug Rider, as set forth on the Schedule of Benefits.