

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.

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.

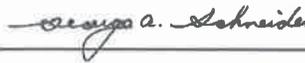
**Español:** Si un Cubrió a Persona que no habla inglés llama el Equipo de Servicio de atención al cliente para la ayuda, un intérprete apropiado será proporcionado para traducir para el representante del Equipo de Servicio de atención al cliente y el Cubrió a Persona. Tales servicios estarán disponibles 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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**Exhibit 3 - Precertification List**

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**5/8/15 – Sections 3, 4 and Exhibit 4 are provided**

### 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 Device, 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](http://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) **1<sup>st</sup> 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) **2<sup>nd</sup> 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) **3<sup>rd</sup> 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) **4<sup>th</sup> 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) **5<sup>th</sup> 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) **6<sup>th</sup> 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](http://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<sub>1</sub>-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 flibcept)
- Fabrazyme™ (agalsidase beta)
- Firmagon™ (degarelix)
- Flolan™ (epoprostenol)
- Folutyn™ (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)
- Orenicia™ (abatacept)
- Orthovisc™ (hyaluronate sodium)
- Perjeta™ (pertuzumab)
- Prialt™ (ziconotide intrathecal infusion)
- Procrit™ (epoetin alfa)
- Prolastin™ (human alpha<sub>1</sub>-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<sub>1</sub>-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.**

**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<sup>th</sup> through 16<sup>th</sup> week of gestation or during the first prenatal visit, if such a visit is later than the 12<sup>th</sup> – 16<sup>th</sup> 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.