BENEFIT	COPAYMENT/COINSURANCE
DEDUCTIBLE	$500 SINGLE $1,000 FAMILY
COINSURANCE MAXIMUM	$2,500 SINGLE $5,000 FAMILY
CARDIAC REHABILITATION (Benefit Limit of 36 sessions per Member per Benefit Period)	$0 per Session
DIABETIC EQUIPMENT, SUPPLIES, DRUGS	
- Prescription drug**	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider
- Diabetic foot orthotics	10% Coinsurance
- Diabetic medical equipment	$0
- Blood glucose test strips** (Copayment per 100 strips)	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider Applied per 100 strips (1-100 strips = 1 Copayment 101-200 strips = 2 Copayments 201-300 strips = 3 Copayments, etc...)
DIABETIC EYE EXAMINATION	$0
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	10% Coinsurance
DURABLE MEDICAL EQUIPMENT ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
EMERGENCY SERVICES	
- Hospital emergency room (Copayment waived if admitted)	$100 per Visit
ENTERAL FEEDING (not subject to a Deductible) $DJDE JDE=GHBY,FEED=LARG,END;	10% Coinsurance
HOME HEALTH CARE	
- Primary Care Physician visits	10% Coinsurance
- Specialist visits	10% Coinsurance
- Other professional visits	$0 per Day of Service
HOSPICE SERVICES ($10,000 Benefit Limit per Member per lifetime)	10% Coinsurance
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES	
- Inpatient Primary Care Physician services	10% Coinsurance
- Inpatient hospital facility services	10% Coinsurance
- Inpatient hospital specialist services	10% Coinsurance

- Outpatient Ambulatory Surgical Center and hospital facility services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital physician services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital surgery services	10% Coinsurance
IMPLANTED DEVICES	
- Drug delivery**	50% Coinsurance per Device
- Contraception	$0
- all other implanted devices	10% Coinsurance
INJECTABLES	10% Coinsurance
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY	
- Post-mastectomy reconstructive surgery	10% Coinsurance
- Breast prosthesis	$0
- surgically implanted	
- external	
MATERNITY CARE	
- Office visit	$0
- Office diagnostic services/procedures	10% Coinsurance
- Inpatient facility services	10% Coinsurance
- Inpatient Specialist services	10% Coinsurance
- Inpatient Primary Care Physician services	10% Coinsurance
MENTAL HEALTH SERVICES	
- Outpatient professional services	
- Individual therapy	10% Coinsurance
- Group therapy	10% Coinsurance
- Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
- Non-Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
MRI/CAT SCAN/PET SCAN/MRA/ NUCLEAR CARDIOLOGY	10% Coinsurance
ORTHOTIC DEVICES**	10% Coinsurance
OSTOMY SUPPLIES	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

PHYSICIAN OFFICE SERVICES	
- Primary Care Physician office visits	10% Coinsurance
- Primary Care Physician routine physicals	$0
- Specialist office visits	10% Coinsurance
- Diagnostic Services/Procedures	10% Coinsurance
PREVENTIVE SERVICES:	$0
- SEE EXHIBIT 2 TO CERTIFICATE FOR A LIST OF PREVENTIVE SERVICES WITH $0 COPAYMENT	

- PERIODIC HEALTH ASSESSMENTS - Chlamydia screening (limited to women ages 16-25) - Pap smear - Annual mammogram - DEXA scan - Cholesterol screening - Lipid panel - WELL CHILD CARE - Hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months) - PEDIATRIC IMMUNIZATIONS - ADULT IMMUNIZATIONS - DIABETES CARE - HbA1c test - LDL-C screening - Nephropathy screening - COLORECTAL SCREENING - Fecal occult blood testing - Flexible sigmoidoscopy - Colonoscopy	
PULMONARY FUNCTION TESTS	$0
PROSTHETIC DEVICES ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
PULMONARY REHABILITATION (Benefit Limit of 36 visits per Member per Benefit Period)	$0 per Visit
REHABILITATIVE SERVICES (Benefit Limit of 45 days of service per Member per Benefit Period)	
- Physical therapy	10% Coinsurance
- Speech therapy	10% Coinsurance
- Occupational therapy	10% Coinsurance
SELECT INJECTABLE DRUGS	$100 Copayment (per injection or infusion not to exceed $1,500 per Member per Benefit Period)
SKILLED NURSING FACILITY SERVICES (Benefit Limit of 60 days of any period of confinement per Member)	10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;	
SUBSTANCE ABUSE	
- Inpatient Hospital Detoxification Services	10% Coinsurance
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment	10% Coinsurance

per Member per lifetime)		
- Substance Abuse Rehabilitation		
- Non Hospital Residential Inpatient		10% Coinsurance
- Outpatient Rehabilitation Services		10% Coinsurance
- Partial Hospitalization		10% Coinsurance
SURGERY FOR TREATMENT OF MORBID OBESITY		$2,000 Facility Copayment
TRANSPORTATION SERVICES		
- Emergency Services		10% Coinsurance
- Scheduled Services		10% Coinsurance
URGENT CARE		
- Urgent Care Facility Services		10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;		
UROLOGICAL SUPPLIES		10% Coinsurance
WELL CHILD OFFICE VISITS (limited to ages 0-21)		$0
WELL WOMAN EXAMS		$0

**THE COST SHARING FOR THIS SERVICE IS NOT SUBJECT TO THE DEDUCTIBLE OR COINSURANCE MAXIMUM AMOUNTS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: TERMINATE END OF YEAR: DEPENDENT 26 / STUDENT 26

ADDITIONAL BENEFITS CURRENTLY IN FORCE FOR THIS CERTIFICATE

ADSOCHCI - #M-151-664-F - 01/13	MANIPULATIVE TREATMENT SERVICES	10% Coinsurance
CITAMEN5 - #M-151-576-F - 01/13	CITIGROUP AMENDMENT	
AMSONS08 - #M-151-740-F - 04/10	NON-SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSOWIS3 - #M-151-603-F - 04/10	IMPACTED WISDOM TEETH	No Copayment/Coinsurance
ADSORCIT - #M-151-666-F - 01/13	REFRACTIONS	No Copayment/Coinsurance
AMSOSM08 - #M-151-739-F - 04/10	SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSLCITI - #M-151-799-F - 01/13	AUTISM SPECTRUM DISORDER SERVICES	See specific Benefit Cost Sharing above
5DHHYNJ1 - #M-151-610-F - 04/12	PRESCRIPTIONS	Copayment for 34-day supply: $10 copay 1st tier, $20 copay 2nd tier, $40 copay 3rd tier, with contraceptive coverage, 20% coinsurance for human growth hormone $0 deductible mailorder 2x prescription drug copayment
CITDOM01 - #M-152-056-F - 01/13	DOMESTIC PARTNER WITH DEPENDENTS	
ADSOMHP2	MENTAL HEALTH AND SUBSTANCE ABUSE (51+)	See Section 3.17.1, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES of your subscription certificate
ADSOWW01 - #M-152-015-F - 08/12	SUBSCRIPTION CERTIFICATE	CONTRACEPTIVE DRUGS/DEVICES

	AMENDMENT	-Single source brand name drugs/devices and Generic drugs/devices --$0 Copayment -Multi source brand name drugs/devices --Copay per outpatient prescription drug rider or 50% Coinsurance for Members with no prescription drug rider
#M-150-841-F - 04/10	Subscription Certificate	
	Date printed 01/22/2013	

BENEFIT	COPAYMENT/COINSURANCE
DEDUCTIBLE	$500 SINGLE $1,000 FAMILY
COINSURANCE MAXIMUM	$2,500 SINGLE $5,000 FAMILY
CARDIAC REHABILITATION (Benefit Limit of 36 sessions per Member per Benefit Period)	$0 per Session
DIABETIC EQUIPMENT, SUPPLIES, DRUGS	
- Prescription drug**	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider
- Diabetic foot orthotics	10% Coinsurance
- Diabetic medical equipment	$0
- Blood glucose test strips** (Copayment per 100 strips)	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider Applied per 100 strips (1-100 strips = 1 Copayment 101-200 strips = 2 Copayments 201-300 strips = 3 Copayments, etc...)
DIABETIC EYE EXAMINATION	$0
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	10% Coinsurance
DURABLE MEDICAL EQUIPMENT ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
EMERGENCY SERVICES	
- Hospital emergency room (Copayment waived if admitted)	$100 per Visit
ENTERAL FEEDING (not subject to a Deductible) $DJDE JDE=GHBY,FEED=LARG,END;	10% Coinsurance
HOME HEALTH CARE	
- Primary Care Physician visits	10% Coinsurance
- Specialist visits	10% Coinsurance
- Other professional visits	$0 per Day of Service
HOSPICE SERVICES ($10,000 Benefit Limit per Member per lifetime)	10% Coinsurance
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES	
- Inpatient Primary Care Physician services	10% Coinsurance
- Inpatient hospital facility services	10% Coinsurance
- Inpatient hospital specialist services	10% Coinsurance

- Outpatient Ambulatory Surgical Center and hospital facility services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital physician services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital surgery services	10% Coinsurance
IMPLANTED DEVICES	
- Drug delivery**	50% Coinsurance per Device
- Contraception	$0
- all other implanted devices	10% Coinsurance
INJECTABLES	10% Coinsurance
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY	
- Post-mastectomy reconstructive surgery	10% Coinsurance
- Breast prosthesis	$0
- surgically implanted	
- external	
MATERNITY CARE	
- Office visit	$0
- Office diagnostic services/procedures	10% Coinsurance
- Inpatient facility services	10% Coinsurance
- Inpatient Specialist services	10% Coinsurance
- Inpatient Primary Care Physician services	10% Coinsurance
MENTAL HEALTH SERVICES	
- Outpatient professional services	
- Individual therapy	10% Coinsurance
- Group therapy	10% Coinsurance
- Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
- Non-Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
MRI/CAT SCAN/PET SCAN/MRA/ NUCLEAR CARDIOLOGY	10% Coinsurance
ORTHOTIC DEVICES**	10% Coinsurance
OSTOMY SUPPLIES	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

PHYSICIAN OFFICE SERVICES	
- Primary Care Physician office visits	10% Coinsurance
- Primary Care Physician routine physicals	$0
- Specialist office visits	10% Coinsurance
- Diagnostic Services/Procedures	10% Coinsurance
PREVENTIVE SERVICES:	$0
- SEE EXHIBIT 2 TO CERTIFICATE FOR A LIST OF PREVENTIVE SERVICES WITH $0 COPAYMENT	

- PERIODIC HEALTH ASSESSMENTS - Chlamydia screening (limited to women ages 16-25) - Pap smear - Annual mammogram - DEXA scan - Cholesterol screening - Lipid panel - WELL CHILD CARE - Hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months) - PEDIATRIC IMMUNIZATIONS - ADULT IMMUNIZATIONS - DIABETES CARE - HbA1c test - LDL-C screening - Nephropathy screening - COLORECTAL SCREENING - Fecal occult blood testing - Flexible sigmoidoscopy - Colonoscopy	
PULMONARY FUNCTION TESTS	$0
PROSTHETIC DEVICES ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
PULMONARY REHABILITATION (Benefit Limit of 36 visits per Member per Benefit Period)	$0 per Visit
REHABILITATIVE SERVICES (Benefit Limit of 45 days of service per Member per Benefit Period)	
- Physical therapy	10% Coinsurance
- Speech therapy	10% Coinsurance
- Occupational therapy	10% Coinsurance
SELECT INJECTABLE DRUGS	$100 Copayment (per injection or infusion not to exceed $1,500 per Member per Benefit Period)
SKILLED NURSING FACILITY SERVICES (Benefit Limit of 60 days of any period of confinement per Member)	10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;	
SUBSTANCE ABUSE	
- Inpatient Hospital Detoxification Services	10% Coinsurance
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment	10% Coinsurance

per Member per lifetime)		
- Substance Abuse Rehabilitation		
- Non Hospital Residential Inpatient		10% Coinsurance
- Outpatient Rehabilitation Services		10% Coinsurance
- Partial Hospitalization		10% Coinsurance
SURGERY FOR TREATMENT OF MORBID OBESITY		$2,000 Facility Copayment
TRANSPORTATION SERVICES		
- Emergency Services		10% Coinsurance
- Scheduled Services		10% Coinsurance
URGENT CARE		
- Urgent Care Facility Services		10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;		
UROLOGICAL SUPPLIES		10% Coinsurance
WELL CHILD OFFICE VISITS (limited to ages 0-21)		$0
WELL WOMAN EXAMS		$0

**THE COST SHARING FOR THIS SERVICE IS NOT SUBJECT TO THE DEDUCTIBLE OR COINSURANCE MAXIMUM AMOUNTS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: TERMINATE END OF YEAR: DEPENDENT 26 / STUDENT 26

ADDITIONAL BENEFITS CURRENTLY IN FORCE FOR THIS CERTIFICATE

ADSOCHCI - #M-151-664-F - 01/13	MANIPULATIVE TREATMENT SERVICES	10% Coinsurance
CITAMEN5 - #M-151-576-F - 01/13	CITIGROUP AMENDMENT	
AMSONS08 - #M-151-740-F - 04/10	NON-SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSOWIS3 - #M-151-603-F - 04/10	IMPACTED WISDOM TEETH	No Copayment/Coinsurance
ADSORCIT - #M-151-666-F - 01/13	REFRACTIONS	No Copayment/Coinsurance
AMSOSM08 - #M-151-739-F - 04/10	SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSLCITI - #M-151-799-F - 01/13	AUTISM SPECTRUM DISORDER SERVICES	See specific Benefit Cost Sharing above
5DHHYNJ1 - #M-151-610-F - 04/12	PRESCRIPTIONS	Copayment for 34-day supply: $10 copay 1st tier, $20 copay 2nd tier, $40 copay 3rd tier, with contraceptive coverage, 20% coinsurance for human growth hormone $0 deductible mailorder 2x prescription drug copayment
CITDOM01 - #M-152-056-F - 01/13	DOMESTIC PARTNER WITH DEPENDENTS	
ADSOMHP2	MENTAL HEALTH AND SUBSTANCE ABUSE (51+)	See Section 3.17.1, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES of your subscription certificate
ADSOWW01 - #M-152-015-F - 08/12	SUBSCRIPTION CERTIFICATE	CONTRACEPTIVE DRUGS/DEVICES

	AMENDMENT	-Single source brand name drugs/devices and Generic drugs/devices --$0 Copayment -Multi source brand name drugs/devices --Copay per outpatient prescription drug rider or 50% Coinsurance for Members with no prescription drug rider
#M-150-841-F - 04/10	Subscription Certificate	
	Date printed 01/22/2013	

BENEFIT	COINSURANCE MAXIMUM
DEDUCTIBLE	$500 SINGLE $1,000 FAMILY
	$2,500 SINGLE $5,000 FAMILY
	COPAYMENT/COINSURANCE
CARDIAC REHABILITATION (Benefit Limit of 36 sessions per Member per Benefit Period)	$0 per Session
DIABETIC EQUIPMENT, SUPPLIES, DRUGS	
- Prescription drug**	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider
- Diabetic foot orthotics	10% Coinsurance
- Diabetic medical equipment	$0
- Blood glucose test strips** (Copayment per 100 strips)	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider Applied per 100 strips (1-100 strips = 1 Copayment 101-200 strips = 2 Copayments 201-300 strips = 3 Copayments, etc...)
DIABETIC EYE EXAMINATION	$0
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	10% Coinsurance
DURABLE MEDICAL EQUIPMENT ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
EMERGENCY SERVICES	
- Hospital emergency room (Copayment waived if admitted)	$100 per Visit
ENTERAL FEEDING (not subject to a Deductible)	10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;	
HOME HEALTH CARE	
- Primary Care Physician visits	10% Coinsurance
- Specialist visits	10% Coinsurance
- Other professional visits	$0 per Day of Service
HOSPICE SERVICES ($10,000 Benefit Limit per Member per lifetime)	10% Coinsurance
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES	
- Inpatient Primary Care Physician services	10% Coinsurance
- Inpatient hospital facility services	10% Coinsurance
- Inpatient hospital specialist services	10% Coinsurance

- Outpatient Ambulatory Surgical Center and hospital facility services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital physician services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital surgery services	10% Coinsurance
IMPLANTED DEVICES	
- Drug delivery**	50% Coinsurance per Device
- Contraception	$0
- all other implanted devices	10% Coinsurance
INJECTABLES	10% Coinsurance
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY	
- Post-mastectomy reconstructive surgery	10% Coinsurance
- Breast prosthesis	$0
- surgically implanted	
- external	
MATERNITY CARE	
- Office visit	$0
- Office diagnostic services/procedures	10% Coinsurance
- Inpatient facility services	10% Coinsurance
- Inpatient Specialist services	10% Coinsurance
- Inpatient Primary Care Physician services	10% Coinsurance
MENTAL HEALTH SERVICES	
- Outpatient professional services	
- Individual therapy	10% Coinsurance
- Group therapy	10% Coinsurance
- Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
- Non-Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
MRI/CAT SCAN/PET SCAN/MRA/ NUCLEAR CARDIOLOGY	10% Coinsurance
ORTHOTIC DEVICES**	10% Coinsurance
OSTOMY SUPPLIES	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

PHYSICIAN OFFICE SERVICES	
- Primary Care Physician office visits	10% Coinsurance
- Primary Care Physician routine physicals	$0
- Specialist office visits	10% Coinsurance
- Diagnostic Services/Procedures	10% Coinsurance
PREVENTIVE SERVICES:	$0
- SEE EXHIBIT 2 TO CERTIFICATE FOR A LIST OF PREVENTIVE SERVICES WITH $0 COPAYMENT	

- PERIODIC HEALTH ASSESSMENTS - Chlamydia screening (limited to women ages 16-25) - Pap smear - Annual mammogram - DEXA scan - Cholesterol screening - Lipid panel - WELL CHILD CARE - Hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months) - PEDIATRIC IMMUNIZATIONS - ADULT IMMUNIZATIONS - DIABETES CARE - HbA1c test - LDL-C screening - Nephropathy screening - COLORECTAL SCREENING - Fecal occult blood testing - Flexible sigmoidoscopy - Colonoscopy	
PULMONARY FUNCTION TESTS	$0
PROSTHETIC DEVICES ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
PULMONARY REHABILITATION (Benefit Limit of 36 visits per Member per Benefit Period)	$0 per Visit
REHABILITATIVE SERVICES (Benefit Limit of 45 days of service per Member per Benefit Period)	
- Physical therapy	10% Coinsurance
- Speech therapy	10% Coinsurance
- Occupational therapy	10% Coinsurance
SELECT INJECTABLE DRUGS	$100 Copayment (per injection or infusion not to exceed $1,500 per Member per Benefit Period)
SKILLED NURSING FACILITY SERVICES (Benefit Limit of 60 days of any period of confinement per Member)	10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;	
SUBSTANCE ABUSE	
- Inpatient Hospital Detoxification Services	10% Coinsurance
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment	10% Coinsurance

per Member per lifetime)		
- Substance Abuse Rehabilitation		
- Non Hospital Residential Inpatient		10% Coinsurance
- Outpatient Rehabilitation Services		10% Coinsurance
- Partial Hospitalization		10% Coinsurance
SURGERY FOR TREATMENT OF MORBID OBESITY		$2,000 Facility Copayment
TRANSPORTATION SERVICES		
- Emergency Services		10% Coinsurance
- Scheduled Services		10% Coinsurance
URGENT CARE		
- Urgent Care Facility Services		10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;		
UROLOGICAL SUPPLIES		10% Coinsurance
WELL CHILD OFFICE VISITS (limited to ages 0-21)		$0
WELL WOMAN EXAMS		$0

**THE COST SHARING FOR THIS SERVICE IS NOT SUBJECT TO THE DEDUCTIBLE OR COINSURANCE MAXIMUM AMOUNTS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: TERMINATE END OF YEAR: DEPENDENT 26 / STUDENT 26

ADDITIONAL BENEFITS CURRENTLY IN FORCE FOR THIS CERTIFICATE

ADSOCHCI - #M-151-664-F - 01/13	MANIPULATIVE TREATMENT SERVICES	10% Coinsurance
CITAMEN5 - #M-151-576-F - 01/13	CITIGROUP AMENDMENT	
AMSONS08 - #M-151-740-F - 04/10	NON-SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSOWIS3 - #M-151-603-F - 04/10	IMPACTED WISDOM TEETH	No Copayment/Coinsurance
ADSORCIT - #M-151-666-F - 01/13	REFRACTIONS	No Copayment/Coinsurance
AMSOSM08 - #M-151-739-F - 04/10	SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSLCITI - #M-151-799-F - 01/13	AUTISM SPECTRUM DISORDER SERVICES	See specific Benefit Cost Sharing above
5DHHYNJ1 - #M-151-610-F - 04/12	PRESCRIPTIONS	Copayment for 34-day supply: $10 copay 1st tier, $20 copay 2nd tier, $40 copay 3rd tier, with contraceptive coverage, 20% coinsurance for human growth hormone $0 deductible mailorder 2x prescription drug copayment
CITDOM01 - #M-152-056-F - 01/13	DOMESTIC PARTNER WITH DEPENDENTS	
ADSOMHP2	MENTAL HEALTH AND SUBSTANCE ABUSE (51+)	See Section 3.17.1, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES of your subscription certificate
ADSOWW01 - #M-152-015-F - 08/12	SUBSCRIPTION CERTIFICATE	CONTRACEPTIVE DRUGS/DEVICES

	AMENDMENT	-Single source brand name drugs/devices and Generic drugs/devices --$0 Copayment -Multi source brand name drugs/devices --Copay per outpatient prescription drug rider or 50% Coinsurance for Members with no prescription drug rider
#M-150-841-F - 04/10	Subscription Certificate	
	Date printed 01/22/2013	

BENEFIT	COPAYMENT/COINSURANCE
DEDUCTIBLE	$500 SINGLE $1,000 FAMILY
COINSURANCE MAXIMUM	$2,500 SINGLE $5,000 FAMILY
CARDIAC REHABILITATION (Benefit Limit of 36 sessions per Member per Benefit Period)	$0 per Session
DIABETIC EQUIPMENT, SUPPLIES, DRUGS	
- Prescription drug**	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider
- Diabetic foot orthotics	10% Coinsurance
- Diabetic medical equipment	$0
- Blood glucose test strips** (Copayment per 100 strips)	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider Applied per 100 strips (1-100 strips = 1 Copayment 101-200 strips = 2 Copayments 201-300 strips = 3 Copayments, etc...)
DIABETIC EYE EXAMINATION	$0
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	10% Coinsurance
DURABLE MEDICAL EQUIPMENT ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
EMERGENCY SERVICES	
- Hospital emergency room (Copayment waived if admitted)	$100 per Visit
ENTERAL FEEDING (not subject to a Deductible) $DJDE JDE=GHBY,FEED=LARG,END;	10% Coinsurance
HOME HEALTH CARE	
- Primary Care Physician visits	10% Coinsurance
- Specialist visits	10% Coinsurance
- Other professional visits	$0 per Day of Service
HOSPICE SERVICES ($10,000 Benefit Limit per Member per lifetime)	10% Coinsurance
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES	
- Inpatient Primary Care Physician services	10% Coinsurance
- Inpatient hospital facility services	10% Coinsurance
- Inpatient hospital specialist services	10% Coinsurance

- Outpatient Ambulatory Surgical Center and hospital facility services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital physician services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital surgery services	10% Coinsurance
IMPLANTED DEVICES	
- Drug delivery**	50% Coinsurance per Device
- Contraception	$0
- all other implanted devices	10% Coinsurance
INJECTABLES	10% Coinsurance
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY	
- Post-mastectomy reconstructive surgery	10% Coinsurance
- Breast prosthesis	$0
- surgically implanted	
- external	
MATERNITY CARE	
- Office visit	$0
- Office diagnostic services/procedures	10% Coinsurance
- Inpatient facility services	10% Coinsurance
- Inpatient Specialist services	10% Coinsurance
- Inpatient Primary Care Physician services	10% Coinsurance
MENTAL HEALTH SERVICES	
- Outpatient professional services	
- Individual therapy	10% Coinsurance
- Group therapy	10% Coinsurance
- Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
- Non-Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
MRI/CAT SCAN/PET SCAN/MRA/ NUCLEAR CARDIOLOGY	10% Coinsurance
ORTHOTIC DEVICES**	10% Coinsurance
OSTOMY SUPPLIES	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

PHYSICIAN OFFICE SERVICES	
- Primary Care Physician office visits	10% Coinsurance
- Primary Care Physician routine physicals	$0
- Specialist office visits	10% Coinsurance
- Diagnostic Services/Procedures	10% Coinsurance
PREVENTIVE SERVICES:	$0
- SEE EXHIBIT 2 TO CERTIFICATE FOR A LIST OF PREVENTIVE SERVICES WITH $0 COPAYMENT	

- PERIODIC HEALTH ASSESSMENTS - Chlamydia screening (limited to women ages 16-25) - Pap smear - Annual mammogram - DEXA scan - Cholesterol screening - Lipid panel - WELL CHILD CARE - Hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months) - PEDIATRIC IMMUNIZATIONS - ADULT IMMUNIZATIONS - DIABETES CARE - HbA1c test - LDL-C screening - Nephropathy screening - COLORECTAL SCREENING - Fecal occult blood testing - Flexible sigmoidoscopy - Colonoscopy	
PULMONARY FUNCTION TESTS	$0
PROSTHETIC DEVICES ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
PULMONARY REHABILITATION (Benefit Limit of 36 visits per Member per Benefit Period)	$0 per Visit
REHABILITATIVE SERVICES (Benefit Limit of 45 days of service per Member per Benefit Period)	
- Physical therapy	10% Coinsurance
- Speech therapy	10% Coinsurance
- Occupational therapy	10% Coinsurance
SELECT INJECTABLE DRUGS	$100 Copayment (per injection or infusion not to exceed $1,500 per Member per Benefit Period)
SKILLED NURSING FACILITY SERVICES (Benefit Limit of 60 days of any period of confinement per Member)	10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;	
SUBSTANCE ABUSE	
- Inpatient Hospital Detoxification Services	10% Coinsurance
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment	10% Coinsurance

per Member per lifetime)		
- Substance Abuse Rehabilitation		
- Non Hospital Residential Inpatient		10% Coinsurance
- Outpatient Rehabilitation Services		10% Coinsurance
- Partial Hospitalization		10% Coinsurance
SURGERY FOR TREATMENT OF MORBID OBESITY		$2,000 Facility Copayment
TRANSPORTATION SERVICES		
- Emergency Services		10% Coinsurance
- Scheduled Services		10% Coinsurance
URGENT CARE		
- Urgent Care Facility Services		10% Coinsurance
$DJDE JDE=GHBY,FEED=LARG,END;		
UROLOGICAL SUPPLIES		10% Coinsurance
WELL CHILD OFFICE VISITS (limited to ages 0-21)		$0
WELL WOMAN EXAMS		$0

**THE COST SHARING FOR THIS SERVICE IS NOT SUBJECT TO THE DEDUCTIBLE OR COINSURANCE MAXIMUM AMOUNTS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: TERMINATE END OF YEAR: DEPENDENT 26 / STUDENT 26

ADDITIONAL BENEFITS CURRENTLY IN FORCE FOR THIS CERTIFICATE

ADSOCHCI - #M-151-664-F - 01/13	MANIPULATIVE TREATMENT SERVICES	10% Coinsurance
CITAMEN5 - #M-151-576-F - 01/13	CITIGROUP AMENDMENT	
AMSONS08 - #M-151-740-F - 04/10	NON-SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSOWIS3 - #M-151-603-F - 04/10	IMPACTED WISDOM TEETH	No Copayment/Coinsurance
ADSORCIT - #M-151-666-F - 01/13	REFRACTIONS	No Copayment/Coinsurance
AMSOSM08 - #M-151-739-F - 04/10	SERIOUS MENTAL ILLNESS	See Cost Sharing Above
ADSLCITI - #M-151-799-F - 01/13	AUTISM SPECTRUM DISORDER SERVICES	See specific Benefit Cost Sharing above
5DHHYNJ1 - #M-151-610-F - 04/12	PRESCRIPTIONS	Copayment for 34-day supply: $10 copay 1st tier, $20 copay 2nd tier, $40 copay 3rd tier, with contraceptive coverage, 20% coinsurance for human growth hormone $0 deductible mailorder 2x prescription drug copayment
CITDOM01 - #M-152-056-F - 01/13	DOMESTIC PARTNER WITH DEPENDENTS	
ADSOMHP2	MENTAL HEALTH AND SUBSTANCE ABUSE (51+)	See Section 3.17.1, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES of your subscription certificate
ADSOWW01 - #M-152-015-F - 08/12	SUBSCRIPTION CERTIFICATE	CONTRACEPTIVE DRUGS/DEVICES

	AMENDMENT	-Single source brand name drugs/devices and Generic drugs/devices --$0 Copayment -Multi source brand name drugs/devices --Copay per outpatient prescription drug rider or 50% Coinsurance for Members with no prescription drug rider
#M-150-841-F - 04/10	Subscription Certificate	
	Date printed 01/22/2013	

DEDUCTIBLE	$500 SINGLE $1,000 FAMILY
COINSURANCE MAXIMUM	$2,500 SINGLE $5,000 FAMILY
BENEFIT	COPAYMENT/COINSURANCE
-------	---------------------
CARDIAC REHABILITATION (Benefit Limit of 36 sessions per Member per Benefit Period)	$0 per Session
DIABETIC EQUIPMENT, SUPPLIES, DRUGS	
- Prescription drug**	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider
- Diabetic foot orthotics	10% Coinsurance
- Diabetic medical equipment	$0
- Blood glucose test strips** (Copayment per 100 strips)	10% Coinsurance or Copayment per Outpatient Prescription Drug Rider Applied per 100 strips (1-100 strips = 1 Copayment 101-200 strips = 2 Copayments 201-300 strips = 3 Copayments, etc...)
DIABETIC EYE EXAMINATION	$0
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	10% Coinsurance
DURABLE MEDICAL EQUIPMENT ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
EMERGENCY SERVICES	
- Hospital emergency room (Copayment waived if admitted)	$100 per Visit
ENTERAL FEEDING (not subject to a Deductible)	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

HOME HEALTH CARE	
- Primary Care Physician visits	10% Coinsurance
- Specialist visits	10% Coinsurance
- Other professional visits	$0 per Day of Service
HOSPICE SERVICES ($10,000 Benefit Limit per Member per lifetime)	10% Coinsurance
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES	
- Inpatient Primary Care Physician services	10% Coinsurance
- Inpatient hospital facility services	10% Coinsurance
- Inpatient hospital specialist services	10% Coinsurance

- Outpatient Ambulatory Surgical Center and hospital facility services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital physician services	10% Coinsurance
- Outpatient Ambulatory Surgical Center and hospital surgery services	10% Coinsurance
IMPLANTED DEVICES	
- Drug delivery**	50% Coinsurance per Device
- Contraception	$0
- all other implanted devices	10% Coinsurance
INJECTABLES	10% Coinsurance
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY	
- Post-mastectomy reconstructive surgery	10% Coinsurance
- Breast prosthesis	$0
- surgically implanted	
- external	
MATERNITY CARE	
- Office visit	$0
- Office diagnostic services/procedures	10% Coinsurance
- Inpatient facility services	10% Coinsurance
- Inpatient Specialist services	10% Coinsurance
- Inpatient Primary Care Physician services	10% Coinsurance
MENTAL HEALTH SERVICES	
- Outpatient professional services	
- Individual therapy	10% Coinsurance
- Group therapy	10% Coinsurance
- Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
- Non-Serious Mental Illness	
- Inpatient facility Services	10% Coinsurance
- Inpatient Professional Services	10% Coinsurance
- Partial Hospital Services	10% Coinsurance
MRI/CAT SCAN/PET SCAN/MRA/ NUCLEAR CARDIOLOGY	10% Coinsurance
ORTHOTIC DEVICES**	10% Coinsurance
OSTOMY SUPPLIES	10% Coinsurance

$DJDE JDE=GHBY,FEED=LARG,END;

PHYSICIAN OFFICE SERVICES	
- Primary Care Physician office visits	10% Coinsurance
- Primary Care Physician routine physicals	$0
- Specialist office visits	10% Coinsurance
- Diagnostic Services/Procedures	10% Coinsurance
PREVENTIVE SERVICES:	$0
- SEE EXHIBIT 2 TO CERTIFICATE FOR A LIST OF PREVENTIVE SERVICES WITH $0 COPAYMENT	

- PERIODIC HEALTH ASSESSMENTS - Chlamydia screening (limited to women ages 16-25) - Pap smear - Annual mammogram - DEXA scan - Cholesterol screening - Lipid panel - WELL CHILD CARE - Hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months) - PEDIATRIC IMMUNIZATIONS - ADULT IMMUNIZATIONS - DIABETES CARE - HbA1c test - LDL-C screening - Nephropathy screening - COLORECTAL SCREENING - Fecal occult blood testing - Flexible sigmoidoscopy - Colonoscopy	
PULMONARY FUNCTION TESTS	$0
PROSTHETIC DEVICES ($5,000 Benefit Limit per Member per Benefit Period)	10% Coinsurance
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- Occupational therapy	10% Coinsurance
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$DJDE JDE=GHBY,FEED=LARG,END;	
SUBSTANCE ABUSE	
- Inpatient Hospital Detoxification Services	10% Coinsurance
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment	10% Coinsurance

per Member per lifetime)		
- Substance Abuse Rehabilitation		
- Non Hospital Residential Inpatient		10% Coinsurance
- Outpatient Rehabilitation Services		10% Coinsurance
- Partial Hospitalization		10% Coinsurance
SURGERY FOR TREATMENT OF MORBID OBESITY		$2,000 Facility Copayment
TRANSPORTATION SERVICES		
- Emergency Services		10% Coinsurance
- Scheduled Services		10% Coinsurance
URGENT CARE		
- Urgent Care Facility Services		10% Coinsurance
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UROLOGICAL SUPPLIES		10% Coinsurance
WELL CHILD OFFICE VISITS (limited to ages 0-21)		$0
WELL WOMAN EXAMS		$0

**THE COST SHARING FOR THIS SERVICE IS NOT SUBJECT TO THE DEDUCTIBLE OR COINSURANCE MAXIMUM AMOUNTS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: TERMINATE END OF YEAR: DEPENDENT 26 / STUDENT 26

ADDITIONAL BENEFITS CURRENTLY IN FORCE FOR THIS CERTIFICATE

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CITAMEN5 - #M-151-576-F - 01/13	CITIGROUP AMENDMENT	
AMSONS08 - #M-151-740-F - 04/10	NON-SERIOUS MENTAL ILLNESS	See Cost Sharing Above
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5DHHYNJ1 - #M-151-610-F - 04/12	PRESCRIPTIONS	Copayment for 34-day supply: $10 copay 1st tier, $20 copay 2nd tier, $40 copay 3rd tier, with contraceptive coverage, 20% coinsurance for human growth hormone $0 deductible mailorder 2x prescription drug copayment
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	AMENDMENT	-Single source brand name drugs/devices and Generic drugs/devices --$0 Copayment -Multi source brand name drugs/devices --Copay per outpatient prescription drug rider or 50% Coinsurance for Members with no prescription drug rider
#M-150-841-F - 04/10	Subscription Certificate	
	Date printed 01/22/2013	

Amendment to the Non-Grandfathered HMO Solutions Subscription Certificate For Citigroup, Inc. Members

GEISINGER HEALTH PLAN®
GROUP HMO

GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822-3220

M-151-576-F Rev. 1/13

GEISINGER HEALTH PLAN®

Dear Subscriber:

This document amends your Subscription Certificate by adding, deleting and revising certain provisions. It would be advisable to reference your Subscription Certificate as you review the revisions detailed in this Amendment as the changes affect the benefits provided to you in your Subscription Certificate. Some of the benefits in this Amendment are those set forth in the Patient Protection and Affordable Care Act ("PPACA") of 2010 (commonly known as Health Care Reform). This Amendment also contains other non-PPACA changes to your benefit documents for the new Benefit Period, effective January 1, 2013.

Some highlights include:

- Extension of dependent coverage to young adults up through the last day of the year in which the young adult turns age 26.
- Removal of lifetime and annual limits on some benefits defined as "essential" (these limits have been removed from the Schedule of Benefits).
- Coverage of certain preventive services at no cost to the Member when provided by a Participating Provider.

The Plan will also remove coverage for pre-existing conditions for all Members. Please keep this Amendment handy for easy reference. If you have any questions about the Amendment revisions, our Customer Service Team will be happy to help. Call them at the number listed on the back of your Member Identification Card.

Sincerely,

Duane E. Davis, M.D.
President and Chief Executive Officer

GEISINGER HEALTH PLAN

AMENDMENT TO THE GEISINGER HEALTH PLAN HMO SUBSCRIPTION CERTIFICATE

The **GEISINGER HEALTH PLAN GROUP HMO SUBSCRIPTION CERTIFICATE ("Certificate") (Rev. 4/10)** to which this Amendment is attached is revised as follows**:**

1. **MODEL NOTICES. As required by the Patient Protection and Affordable Care Act of 2010 ("PPACA") (commonly known as Health Care Reform),** the following Notices are added to the introductory section of the Certificate:

A. **NOTICE OF OPPORTUNITY TO ENROLL IN CONNECTION WITH EXTENSION OF DEPENDENT COVERAGE TO AGE 26.**

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before dependent's attainment of age twenty-six (26), are eligible to enroll in the Plan. The Subscriber must request enrollment for such children within sixty (60) days of the Subscriber's receipt of this Certificate. Enrollment will be effective retroactively to the first day of the Benefit Period.

B. **NOTICE REGARDING REMOVAL OF LIFETIME LIMIT AND ENROLLMENT OPPORTUNITY**

The lifetime limit on the dollar value of essential health benefits and/or total benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching the lifetime limit on the dollar value of total benefits under the Plan are eligible to enroll in the Plan. These Individuals must request enrollment within thirty (30) days of the Subscriber's receipt of this Certificate.

2. SECTION 1. DEFINITIONS

A. Section **1.7**, the definition of "**Certified Review Entity**", and all references to "Certified Review Entity" are deleted from the Certificate.

B. Section **1.16**, **Creditable Coverage,** is hereby amended to delete the last sentence.

C. Section **1.28, Grievance,** is deleted in its entirety and replaced with the following:

1.28 **Grievance** or **Adverse Benefit Determination** is a request by a Member, Participating Provider or Health Care Provider (with the written consent of the Member) to have the Plan reconsider a decision concerning the Medical Necessity and appropriateness of a health care service and/or the Member's eligibility to participate in the Plan. If the Plan is unable to resolve the matter, a Grievance may be filed regarding the determination that does any of the following:

a) disapproves full or partial payment for a requested health service;

b) approves the provision of a requested health care service for a lesser scope or duration than requested;

c) disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service;

d) determines that a Member is ineligible to participate in the Plan; and/or

e) rescission.

D. Section **1.65, Urgent Care**, is deleted in its entirety and replaced with the following:

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

E. The definition, **Mini-COBRA,** is hereby added to this Section as follows:

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

F. The definition, **Provider,** is hereby added to this Section as follows:

Provider shall mean Health Care Provider.

3. SECTION 2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES.

A. Section **2.3**, **Choice of Primary Care Physician,** is deleted from the Certificate and replaced with the following:

2.3 Choice of Primary Care Physician. Upon enrollment, the Subscriber shall choose a Primary Care Physician for himself and for each enrolled Family Dependent. Any child Family Dependent shall be entitled to have a pediatrician as his/her Primary Care Physician. The Provider List indicates the Primary Care Physicians and pediatricians who are part of the Plan's Network.

A Subscriber who fails to choose a Primary Care Physician will be assigned one for himself and each enrolled Family Dependent.

B. Section **2.8, Medical Management Procedures,** subsection **2.8 c)** is deleted from the Certificate and replaced with the following; and subsection g) is added as follows:

c) The Plan's clinical staff is available to assist Members who require transplants, have catastrophic disease or injury, request services outside the Network (when temporarily outside the Service Area and require Urgent Care) or can benefit from individualized attention to coordinate their needs.

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

C. Section **2.8**, **Medical Management Procedures,** shall have the last sentence of the section deleted from the Certificate and replaced with the following:

"The Plan's medical management policies and procedures comply with all National Committee for Quality Assurance standards and applicable state and federal regulations regarding medical management and utilization."

4. SECTION 3. COVERED SERVICES - IDENTIFICATION OF COVERED SERVICES.

A. Section **3.1.2**, **Covered Services from a Non-Participating Provider,** Subsection **3.1.2 (c)** is deleted from the Certificate and replaced with the following:

c) when the Member obtains Prior Authorization because Covered Services are not available from a Participating Provider or cannot be provided within the Service Area; or

B. Section **3.3.4, Outpatient Training and Education,** has its introductory paragraph amended as follows:

"Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered upon Referral by the Member's Primary Care Physician and provided under the supervision of a Participating 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:"

Subsections i, ii and iii shall remain as written in the Certificate.

C. Section **3.6, Durable Medical Equipment (DME), Orthotic Devices and Prosthetic Devices,** is amended as follows:

1. Section **3.6.1 (d)** which defines the term "Standard" is deleted from the Certificate. Use of the defined term is correspondingly deleted throughout the Certificate.

2. Section **3.6.1 (d)** is now added to the Certificate as follows:

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. Section **3.6.4, Prosthetic Devices,** Section **3.6.4.1, Members under Age Nineteen (19),** and Section **3.6.4.2, Manufacturer**, are deleted from the Certificate and replaced with the following:

3.6.4 **Prosthetic Devices**. The Plan will pay for the purchase of one (1) Prosthetic Device or the replacement of component parts or modification of an existing Prosthetic Device every five (5) years when obtained from a Participating Provider subject to the

Exclusions set forth in Section 4.61 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.

3.6.4.1 Member **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.

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

D. Section **3.8, Enteral Feeding/Food Supplements,** is amended, as follows, to include this sentence at the end of the paragraph:

"Upon Prior Authorization, coverage consideration may also be given when enteral or parenteral feeding is the sole source of nutrition."

E. The following Section is added to Section **3.10, Home Health Care,** as set forth below.

3.10.2.1 Benefit Limit. Primary Care Physician home health visits are subject to a Benefit Limit of two hundred (200) visits per Benefit Period.

F. Section **3.15**, **Maternity Care,** is amended to delete the second to last sentence and replace it with the following:

"Certified licensed nurse midwife Participating Provider services shall be covered only if obtained from a Participating Provider."

G. Sections **3.22** through **3.22.7**, **Preventive Services**, are deleted from the Certificate and replaced with the following:

3.22 Preventive Services. The following preventive health care services are covered when obtained from a Participating Provider as set forth in Section 3.1.1 of this Certificate:

3.22.1 **Periodic health assessments** provided upon a schedule advisable by the Member's Primary Care Physician, obstetrical or gynecological Participating Health Care Provider (as applicable) including:

a) physical examination; and

b) for women, an annual gynecological examination, including a pelvic examination and a clinical breast examination.

3.22.1.1 **Periodic Health Assessment Cost Sharing.** For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.22.1, 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.

3.22.2 **Additional Preventive Services listed in Exhibit 2.** The preventive services listed in **Exhibit 2** are not subject to Cost Sharing when obtained from a Participating Provider as set forth in Section 3.1.1 or upon Referral from a Participating Provider.

H. Section **3.26**, **Select Injectable Drugs,** is deleted from the Certificate and replaced with the following:

3.26 Select Injectable Drugs. Subject to the terms and conditions set forth in this Certificate, the following injectable drugs are a Covered Service when provided by a Participating Provider. Such injectable drugs are subject to the Cost Sharing set forth on the Schedule of Benefits and the Plan's right to approve the participating pharmacy vendor for injectable drugs.

- Actemra ™ (tocilizumab)
- Aldurazyme™ (laronidase)
- Amevive™ (alefacept)
- Aralast™ (human $alpha_1$-proteinase inhibitor)
- Aranesp™ (darbepoetin alfa)
- Arranon™ (nelarabine)
- Arzerra™ (ofatumumab)
- Avastin™ (bevacizumab)
- Benlysta™ (belimumab)
- Berinert™ (C1 Esterase Inhibitor Human)
- Boniva™ IV (ibandronate sodium)
- Botox™ (botulinum toxin type A)
- Cerezyme™ (imiglucerase)
- Cimzia™ (certolizumab pegol)
- Cinryze™ (C1-esterase inhibitor)
- Eligard™ (leuprolide)
- Eloxatin™ (oxaliplatin injection)
- Epogen™ (epoetin alfa)
- Erbitux™ (cetuximab)
- Euflexxa™ (hyaluronate sodium)
- Fabrazyme™ (agalsidase beta)
- Firmagon™ (degarelix)
- Flolan™ (epoprostenol)
- Halaven-T™ (eribulin mesylate)
- Hyalgan™ (hyaluronate sodium)
- IVIG™ (intravenous immune globulin)
- Ilaris™ (canakinumab)
- Invega Sustenna™ (paliperidone palmitate)
- Istodax™ (romidepsin)
- Ixempra™ (ixabepilone)
- Jevtana™ (cabazitaxel)
- Kalbitor™ (ecallantide)
- Kepivance™ (palifermin)
- Lucentis™ (ranibizumab)
- Lumizyme™ (alglucosidase alfa)
- Lupron Depot™ (leuprolide acetate)
- Macugen™ (pegaptanib)
- Mozobil™ (plerixafor)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Nplate™ (romiplostim)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Orthovisc™ (hyaluronate sodium)
- Prialt™ (ziconotide intrathecal infusion)
- Procrit™ (epoetin alfa)
- Prolastin™ (human $alpha_1$-proteinase inhibitor)
- Prolia™ (denosumab)

- Provenge™ (sipuleucel-T)
- Reclast™ (zoledronic acid)
- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Risperdal Consta™ (risperidone microspheres)
- Rituxan™ (rituximab)
- Simponi™ (golimumab)
- Soliris ™ (eculizumab)
- Stelara™ (ustekinumab)
- Supartz™ (hyaluronate sodium)
- Synagis™ (palivizumab)
- Synvisc™ (hylan G-F 20)
- Synvisc-1™ (hylan G-F 20)
- Thyrogen™ (thyrotropin alfa)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Trelstar™ (triptorelin)
- Tysabri™ (natalizumab)
- Velcade™ (bortezomib)
- Viadur™ (leuprolide)
- Visudyne™ (verteporfin)
- Vivaglobin™ (subcutaneous immune globulin)
- Vivitrol™ (naltrexone microspheres)
- Xgeva™ (denosumab)
- Xiaflex™ (collagenase clostridium histolyticum)
- Xolair™ (omalizumab)
- Yervoy™ (ipilimumab)
- Zemaira™ (human alpha$_1$-proteinase inhibitor)

I. Section **3.26.1**, **Cost Sharing**, and all references to Section **3.26.1** are deleted from the Certificate. Cost sharing applicable to select injectable drugs has been moved to the Schedule of Benefits.

J. Human Leukocyte Antigen (HLA) Typing is no longer subject to a specific dollar Benefit Limit, therefore, Section **3.29.6**, **Human Leukocyte Antigen (HLA) Typing,** is deleted from the Certificate.

K. Section **3.32**, **Urological Supplies,** is deleted from this Certificate and replaced with the following:

3.32 Urological Supplies. Urological supplies provided by a Participating Provider are covered when the Plan 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.

5. **SECTION 4. EXCLUSIONS.**

A. Section **4.1**, **Acupunctur**e, is deleted from the Certificate in its entirety and replaced within the following:

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.

B. Section **4.4**, **Biofeedback**, is deleted from the Certificate. Biofeedback is now referenced in Section **4.1, Alternative Therapies**, as a type of alternative therapy that is not covered.

C. Section **4.6**, **Breast Surgery**, is deleted from the Certificate and replaced with the following:

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 3.14 of this Certificate.

D. Section **4.8, Complications Resulting from a Non-Covered Procedure or Service,** is deleted from the Certificate.

E. Section **4.10**, **Cosmetic Surgery,** is deleted from this Certificate and replaced with the following:

4.10 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 Plan, is **NOT COVERED**, except as provided in Sections 3.14, 3.25.1 or 3.25.2 of this Certificate.

F. Section **4.14**, **Drugs,** is deleted from this Certificate and replaced with the following:

4.14 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in Certificate Sections 3.3.3, 3.29.7 or as set forth in **Exhibit 2, Preventive Services**, or as may be explicitly provided under the terms of an **Outpatient Prescription Drug Rider** or the **Autism Spectrum Disorder Services Rider** if such Riders are listed on the Schedule of Benefits as being in place with this Certificate.

G. Section **4.37**, **Non-Participating Providers,** is amended to re-word the first sentence, as follows:

"Covered Services or supplies received from Non-Participating Providers are **NOT COVERED**."

H. Section **4.47**, **Private Duty Nursing**, is deleted from the Certificate and replaced with the following:

4.47 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.

I. Section **4.55**, **Services Related to or Required by a Non-Covered Service,** is deleted from the Certificate**.**

J. Section **4.60**, **Weight Control,** is deleted from this Certificate and replaced with the following:

4.60 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.34 of this Certificate or as set forth in **Exhibit 2, Preventive Services.**

K. Section **4.61.6, Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** is deleted from the Certificate and replaced with the following:

4.61.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthotics** of any sort, are **NOT COVERED** except for diabetic foot orthotics which are covered as a Covered Service under Section 3.3.2 of the Certificate.

L. Section **4.61.19**, **Non-Standard Equipment or Devices**, is deleted from the Certificate and replaced with the following:

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

M. Subsection **4.61.21, "Replacement of Component Parts or Modification …"** is deleted from the Certificate and replaced with the following:

4.61.21 **Replacement of Component Parts or Modification** of a Prosthetic Device within five (5) years of obtaining a new or other replacement part(s) unless incident to the Member's growth for a Member who is under the age of nineteen (19) years as set forth in Section 3.6.4.1 of this Certificate is **NOT COVERED**.

N. Section **4.62, Oral Nutrition Products or Supplements** is added to the Certificate as follows:

4.62 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.

O. Section **4.63, Personal and Athletic Trainer Services** is added to the Certificate as follows**:**

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

P. Section **4.64**, **Services Provided in Conjunction with a Non-Covered Service** is added to the Certificate as follows**:**

4.64 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.

6. SECTION 5 COMPLAINT AND GRIEVANCE PROCEDURE.

A. SECTION 5, COMPLAINT AND GRIEVANCE PROCEDURE, is deleted from the Certificate and replaced with the following:

SECTION 5. COMPLAINT AND GRIEVANCE PROCEDURE

The Plan maintains separate Complaint and Grievance processes. The Plan will make a determination as to which process is applicable when a Complaint or Grievance is filed. The Member will be informed of the applicable process in the manner and time period pursuant to applicable State and Federal regulation and as detailed in the remainder of Section 5, below.

5. COMPLAINT AND GRIEVANCE PROCEDURE.

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

A Member may call the Plan's toll-free telephone number located on the back of the Member's Identification Card, Monday through Friday between the hours of 8:00 a.m. to 6:00 p.m. to obtain information regarding the filing and status of a Complaint or Grievance. The Member has the right to provide the Plan with written comments, documents, records or other information regarding the Complaint or Grievance. The Plan will fully and fairly consider all available information relevant to the Complaint or Grievance, including any material submitted by the Member to the Plan, when making a determination. In the event a Member disagrees with the Plan's classification of a Complaint or Grievance/Adverse Benefit Determination, the Member may contact the Department of Health or Department of Insurance for consideration and intervention with the Plan in order to be redirected to the appropriate internal Plan review process. The Complaint or Grievance will also be classified as either a "Pre-Service" appeal or "Post-Service" appeal. "Pre-Service" appeals are appeals regarding services that have not yet occurred. "Post-Service" appeals are appeals for services that have already been rendered.

The Plan may not cancel or terminate a Member's coverage for services provided under this Certificate on the basis that the Member has exercised rights under the Plan's Grievance and Complaint procedure by registering a Complaint or Grievance against the Plan.

5.1 Complaint Procedure.

5.1.1 **First Level Complaint Review Procedure.** A Member who has a Complaint about his coverage, Participating Providers, or the operations or management policies of the Plan should contact the Customer Service Team. A Customer Service Team representative will attempt to satisfy the Member's issue informally. If the Customer Service Team representative is unable to resolve the Member's concern to his satisfaction, the Member may file a written or oral Complaint that will be reviewed by the First Level Complaint Review Committee. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of an adverse benefit determination or the occurrence of the issue, which is the subject of the Complaint. The Plan shall notify the Member of its receipt in writing including a detailed explanation of the Complaint process.

5.1.1.1 **First Level Complaint Review Committee.** The First Level Complaint Review Committee shall include one (1) or more employees of the Plan, or its designee, who did not previously participate in a prior decision to deny the Member's Complaint and shall not be a subordinate of the person(s) who made the adverse benefit determination. Upon request from the Member, the Plan shall provide the Member with access to the information available relating to the matter being complained of at no cost and shall

permit the Member to provide additional verbal or written data or other material in support of the Complaint.

5.1.1.2 **Time Frame for Decision.** The First Level Complaint Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from the receipt of the First Level Complaint and within five (5) business days of the First Level Complaint Review Committee's decision.

5.1.1.3 **Member Notification of Decision.** Notification to the Member shall include the basis for the decision and the procedure to file a request for a voluntary Second Level Complaint Review of the decision of the First Level Complaint Review Committee including:

a) a statement of the issue reviewed by the First Level Complaint Review Committee;

b) the outcome of the first level review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) a list of the titles and qualifications of the individuals participating in the review;

g) notification that the Member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Complaint/appeal at no cost and instructions as to how to obtain the same;

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

i) an explanation of how to request a voluntary Second Level Complaint Review of the decision of the First Level Complaint Review Committee and notification that the Member has the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the voluntary Second Level Complaint Review; and

j) the time frames for requesting a Second Level Complaint Review, if any.

5.1.2 **Second Level Complaint Review Procedure.** A Member who is dissatisfied with the decision of the First Level Complaint Review Committee may request orally or in writing a voluntary Second Level Complaint Review. A written request should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 North Academy Avenue, Danville, PA 17822. An oral request may be made by telephoning the Plan's Customer Service Team Representative. The Plan shall notify the Member of its receipt in writing, upon receipt of such request.

5.1.2.1 **Member Satisfaction Review Committee**. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the Plan or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's Complaint including any material submitted by the Member to the Plan. The Plan shall provide at

least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.1.2.2 **Time Frame for Decision.** The Second Level Complaint Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from the receipt of the Second Level Complaint and within five (5) business days of the Member Satisfaction Review Committee's decision.

5.1.2.3 **Member Notification of Decision.** The written notice shall specify the reasons for the Member Satisfaction Review Committee's decision and shall include the specific reason and basis for the decision and the procedures to file an appeal to the Department of Health or the Department of Insurance including the address and telephone numbers of both agencies and shall include the following information:

a) a statement of the issue reviewed by the Member Satisfaction Review Committee;

b) the outcome of the second level review;

c) the specific reasons for the decision in easily understandable language**;**

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol, or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion and notification that the Member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) a list of titles and qualifications of individuals participating in the review;

g) notification that the Member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Complaint/appeal at no cost and instructions as to how to obtain the same;

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

i) an explanation of how to request an External Complaint Appeal Review of the decision of the Member Satisfaction Review Committee by the Department of Health or the Department of Insurance, including the addresses and telephone numbers of both agencies, a description of the External Complaint Appeal process including notification that the Member has the right to provide additional material for inclusion in the External Complaint Appeal Review and a statement that the Member does not bear any costs for the External Complaint Appeal Review; and

j) the time frame for requesting an External Complaint Appeal Review, if any.

5.1.3 **External Complaint Appeal Review.** If the Member is not satisfied, the Member may appeal the decision of the Member Satisfaction Review Committee within fifteen (15) calendar days from receipt of the notice of the Second Level Complaint Review decision to the Pennsylvania Department of Health:

Bureau of Managed Care

Pennsylvania Department of Health
Health & Welfare Building, Room 912
7th & Forster Streets
Harrisburg, PA 17120
Telephone Number: (717) 787-5193 or 1-(888) 466-2787
AT & T Relay Service: 1-(800) 654-5984 (TT)

Fax Number: (717) 705-0947

OR the Pennsylvania Department of Insurance:

Pennsylvania Department of Insurance
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Telephone Number: (717) 787-2317 or 1-(877)-881-6388
Fax Number: (717) 787-8585

The Plan shall transmit to the appropriate Department all records from the First and Second Level Complaint Review processes within thirty (30) calendar days of the Department's request. The Plan and the Member may submit to the appropriate Department additional materials related to the Complaint. Each party shall provide to the other copies of the additional documents provided to the Department. The Plan and the Member have the right to be represented by an attorney or other individual before the appropriate Department. The appropriate Department shall have the final determination.

5.1.4 **Complaint Regarding Increase to Premium Rates.** A Member who has an inquiry, Complaint or question regarding the Plan's increase to premium rates may contact the Pennsylvania Department of Insurance without the necessity of following the Plan's First and Second Level Complaint Review Procedures.

5.2 Grievance/Adverse Benefit Determinations.

5.2.1 **First Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, may file a **written** request (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) to have the Plan review the Grievance. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of a Grievance and should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 North Academy Avenue, Danville, PA 17822. The Plan shall notify the Member and Health Care Provider who filed the Grievance with the Member's written consent, of its receipt in writing including a detailed explanation of the Grievance process.

5.2.1.1 **First Level Internal Review Committee**. The First Level Internal Review Committee shall include one (1) or more individuals selected by the Plan. The committee consists of a Plan Medical Director (licensed physician) who did not previously participate in any prior decision relating to the Grievance and shall not be subordinates of the person(s) who made the adverse benefit determination. The First Level Internal Review Committee shall include written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the Member or a Health Care Provider with the Member's written consent, the Plan shall provide the Member or the Health Care Provider who filed the Grievance with the Member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material in support of the Grievance.

5.2.1.2 **Time Frame for Decision.** The First Level Grievance Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from receipt of the First Level Grievance and within five (5) business days of the Committee's decision.

5.2.1.3 **Member Notification of Decision**. Written notification to the Member and the filing Health Care Provider shall include the following:

a) a statement of the issue reviewed by the First Level Internal Review Committee;

b) the outcome of the First Level Grievance Review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member or filing Health Care Provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Member's medical circumstances;

g) a list of the titles and qualifications of the individuals participating in the review;

h) notification that the Member or filing Health Care Provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Grievance/appeal at no cost and instructions as to how to obtain the same;

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

j) an explanation of how to request a voluntary Second Level Grievance Review of the decision of the First Level Internal Review Committee and notification that the Member or filing Health Care Provider have the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the voluntary Second Level Grievance Review; and

k) the time frames for requesting a Second Level Grievance Review, if any.

5.2.2 **Second Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the First Level Internal Review Committee may request in **writing** (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) a voluntary Second Level Grievance Review. Upon receipt, the Plan shall notify the Member and Health Care Provider who filed the Grievance of its receipt in writing.

5.2.2.1 **Second Level Internal Review Committee**. The Second Level Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination or of the First Level Internal Review Committee reviewers. The Second Level Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the Member or a Health Care Provider with the Member's written consent, the Plan shall provide the Member or the Health Care Provider who filed the Grievance with the Member's written consent, with access to the

information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the Grievance. The Member and the Health Care Provider who filed a Grievance have the right to appear before the Second Level Internal Review Committee. The Plan and the Member have the right to be represented by an attorney or other individual before the Second Level Internal Review Committee. The Plan shall provide at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Second Level Grievance Review meeting to the Member and the Health Care Provider who filed the Grievance with the Member's written consent.

5.2.2.2 **Time Frame for Decision.** The Second Level Grievance Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from receipt of the Second Level Grievance and within five (5) business days of the Committee's decision.

5.2.2.3 **Member Notification of Decision**. Written notification to the Member and the filing Health Care Provider shall include the following:

a) a statement of the issue reviewed by the Second Level Internal Review Committee;

b) the outcome of the Second Level Grievance Review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provisions on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member or filing Health Care Provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Member's medical circumstances;

g) a list of the titles and qualifications of the individuals participating in the review;

h) notification that the Member or filing Health Care Provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Grievance/appeal at no cost and instructions as to how to obtain the same;

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

j) an explanation of how to request an External Grievance Review conducted by an Independent Review Organization. The decision letter will also include notification that the Member or filing Health Care Provider have the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the External Grievance Appeal Review, including a statement that the Member and Member Representative do not bear any costs of the independent External Grievance Appeal Review.

5.3 Expedited Grievance Review Procedure. Should the Member's life, health or ability to regain maximum function be in jeopardy by delay caused by the Plan's review procedure, the Member or a

Health Care Provider with the Member's written consent, may request an Expedited Grievance Review (orally or in writing). The Plan will perform an Expedited Grievance/Urgent Care Appeal Review when:

a) upon review by the Plan, the Member's request meets medical criteria to initiate the Expedited Grievance Review process; or

b) it is the Health Care Provider's opinion that the Member is subject to severe pain that cannot be managed without the care or treatment being requested; or

c) the Member provides the Plan with a certification, in writing, from the Member's physician stating that the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Pre-Service Grievance Process of thirty (30) days. The certification must include a clinical rationale and facts to support the physician's opinion; or

d) requests concerning admissions, continued stay or other health care service for a Member who has received emergency services but has not been discharged from a facility.

The Plan shall accept the above, perform an Expedited Grievance review and render a decision within forty-eight (48) hours of receipt of the Member's request for an Expedited Grievance Review. The Member shall be responsible to provide information to the Plan in an expedited manner to allow the Plan to conform to the Expedited Grievance Review requirements.

The Expedited Internal Review Committee shall be comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the adverse benefit determination. The Expedited Grievance Review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review.

5.4 External Grievance Review Procedure. If the Member is not satisfied with the Final Grievance Benefit Determination (a Final Adverse Benefit Determination is the decision made by the Plan in regard to a Grievance filed in accordance with Sections 5.2.1 or 5.2.2 above that results in a denial), the Member may have the opportunity to request an external review. Final Adverse Benefit Determinations that meet the federally regulated external appeal criteria are eligible for review by an IRO. Information regarding any appeal rights will be provided to the Member within the Appeal decision notification.

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

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

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

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

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

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

Within one (1) business day after completion of the preliminary review, the Plan must issue written notification to the Member. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete. To complete an incomplete request, the Member will have either the remainder of the four (4) month filing period (as detailed in Section 5.4.1) or within forty-eight (48) hours following the receipt of the notification, whichever is later.

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

a) The Member's medical records;

b) The attending health care professional's recommendation;

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

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

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

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

g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section 5.4.1.2 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

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

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

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

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

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

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

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

5.4.1.4 **Binding Decision**. The Member and the Plan will be bound by the final decision of the IRO except to the extent that other remedies are available under State or Federal law. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require payment or benefits. The Plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external decision and unless or until there is a judicial decision.

5.5 Expedited External Grievance/Adverse Benefit Determination Review Procedure. The Member or the Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the Plan's Expedited Grievance Review as set forth in Section 5.3, may appeal orally or in writing to the Plan within two (2) business days of receipt of the Expedited Grievance Review decision.

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

5.5.1 **Preliminary Review**. If the Plan determines the expedited external review request meets the requirements set forth in section 5.4.1.1, notice will be sent to the Member within one (1) business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

5.5.2 **External Review Procedure**. If an external review is warranted, the Plan will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The Plan will provide all the necessary documents and information considered in making the Final Adverse Benefit Determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.1.2. In reaching a decision, the IRO will review the claim de novo and shall

not be bound by any decisions or conclusions reached during the Plan's internal appeal procedures.

5.5.3 **Notice of the Final External Review Decision.** The IRO will provide notice of the final external review decision in accordance with section 5.4.1.3 (a) through (g) as expeditiously as the Member's medical condition requires, but in no event later than seventy-two (72) hours after the IRO receives a request for an expedited external review. If the notice from the IRO to the Member is not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Member and the Plan.

7. **SECTION 6 - ELIGIBILITY.**

A. Sections **6.2** through **6.2.1** are deleted from the Certificate and replaced with the following:

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

a) The spouse of a Subscriber under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania. Such spouse must reside in the Service Area;

b) A Subscriber's child (married or unmarried) who has not yet attained the age of twenty-six (26) is eligible for enrollment. Eligible children include: newborn children, stepchildren, children legally placed for adoption, children awarded coverage pursuant to an order of court, and legally adopted children of the Subscriber or the Subscriber's spouse. Eligibility shall cease for a dependent child on the last day of the year the child becomes age 26. Such children may live within or outside the Service area but benefits will be limited to those as set forth in this Certificate; and

c) The Subscriber's dependent child (married or unmarried) who is age twenty-six (26) or older, who, (i) as medically certified by a physician, is incapable of self-support due to mental retardation or a physical disability, mental illness or developmental disability and who became so prior to the attainment of age nineteen (19); and (ii) who is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance, may continue enrollment or will become eligible for enrollment under Family Coverage for the duration of such disability and dependency. Such child must reside in the Service Area unless they are covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania.

Eligibility shall cease for a dependent child on the last day of the year the child becomes age 26 (except for disabled dependent children). Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage and the applicable premium for Family coverage is duly paid.

B. Sections **6.2.3** through Section **6.2.5**, **Newborn Child, Adopted Child, and Children Born to Family Dependents,** are deleted from the Certificate and replaced with the following:

6.2.3 **Newborn Child (ren).**

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

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

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

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

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

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

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

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

OR

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

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

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

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

An adopted child, or a child placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse is automatically covered under this Certificate for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from Single to Family Coverage) must be submitted to the Plan within thirty-one (31) days of the date of adoption or date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. The Plan will require documentary proof (i.e., official court documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage.

C. Section **6.2.6**, **Continued Coverage of Disabled Dependent Child,** is deleted from the Certificate and replaced with the following:

6.2.6 **Continued Coverage of Disabled Dependent Child.** A dependent child (married or unmarried) who exceeds the Maximum Age for dependent children and is:

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

b) is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance, may continue enrollment or will become eligible for enrollment under Family Coverage for the duration of such disability and dependency.

In addition, such dependent child must have been enrolled as a Family Dependent under this Certificate prior to reaching the age of nineteen (19) or under the terms of another Group health benefit program offered by the Group as an alternative to the Plan. The Plan may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the Plan is first notified of such disability and dependency, whichever is earlier.

D. Section **6.2.7**, **Students**, is deleted from the Certificate.

E. Section **6.2.7.1, Students – Military Duty,** is renumbered as Section **6.2.7., Military Duty,** and the following definition of full-time student shall be included with Section:

A full-time student shall be an individual who enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study. The Plan may periodically require documentary proof of enrollment as student upon reaching the Maximum Age for dependent children ser forth on the Schedule of Benefits, or upon the date of which the Plan is first notified of such enrollment.

F. Section **6.2.7.2, Continuing Coverage of Full-Time Students on Medical Leave,** is deleted from the Certificate.

G. Section **6.7.3**, **Special Enrollment Period for Members who Lost Dependent Eligibility Status under the Plan Due to Age,** is added to the Certificate as follows:

6.7.3 Special Enrollment Period for Members who Lost Dependent Eligibility Status under the Plan Due to Age. Effective March 23, 2010, any dependent child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under this Plan because, under the terms of the Plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 shall be eligible to (re)-enroll in the Plan. The Plan shall provide the

Subscriber with written notice of such opportunity to enroll a dependent child (ren). A Subscriber shall have sixty (60) days from such notice to enroll a dependent child (ren).

H. Section **6.8, Pre-Existing Condition Exclusion** and sub-sections **6.8.1**, **Exceptions to Pre-Existing Condition Exclusion** and **6.8.2**, **Creditable Coverage** are deleted from the Certificate.

8. **SECTION 9 - TERM AND TERMINATION.**

A. Sections **9.3.2.1, Fraud or Material Misrepresentation By the Group,** and **9.3.2.2**, **By the Member,** referencing misrepresentation in the securing of any benefits and/or any coverage under this Plan, are further clarified as meaning any "intentional misrepresentation of a material fact".

B. Section **9.3.7** is deleted from this Certificate and replaced with the following:

9.3.7 **Residence Out of the Service Area.** To be eligible to enroll and to continue enrollment in the Plan, the following Members, as applicable, must be a full-time resident(s) of the Service Area: (a) Subscriber; (b) Subscriber's spouse; and/or (c) a dependent disabled child age 26 years or older, unless covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania. If any of these Members are absent from the Service Area for more than ninety (90) consecutive days or work within the Service Area but no longer lives within twenty (20) miles or twenty (20) minutes of a Participating Primary Care Physician, such Member shall no longer be considered a permanent resident of the Service Area and coverage shall be terminated upon fifteen (15) days written notice by the Plan to the Subscriber.

9. Exhibit 1 – <u>GEISINGER HEALTH PLAN SERVICE AREA</u>

A. This Exhibit is amended to include Fulton County.

10. Exhibit 2 – <u>PREVENTIVE SERVICES.</u>

A. The Certificate is amended to include the following Exhibit 2:

<u>Exhibit 2</u>
<u>Preventive Services</u>

The following preventive health care Covered Services are covered under this Plan with no Member Cost Sharing when obtained from a Participating Provider as set forth in Section 3.1.1 of this Certificate or upon Referral from a Participating Provider:

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) and the Health Resources and Services Administration (HRSA).

1. **Periodic health assessments** provided upon a schedule advisable by the Member's Primary Care Physician, obstetrical or gynecological Participating Health Care Provider (as applicable) 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;

d) annual mammogram for women forty (40) years of age and older or any mammogram based on the Member's Primary Care Physician's, obstetrical or gynecological Participating Health Care 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 Plan.

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) Screening** for adolescents and adults**.**

g) **Obesity screening/counseling** for adults and children age 6 and older.

h) **Syphilis screening** as determined by the PCP or OB GYN Participating 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.

6. **Pregnancy related Preventive Services which include:**

a) **Bacteruria screening** for pregnant women in the 12^{th} through 16^{th} week of gestation or during the first prenatal visit, if such a visit is later than the 12^{th} – 16^{th} week period.

b) **Iron deficiency anemia screening** in asymptomatic pregnant women.

c) **Rh (D) blood typing and antibody testing** for all pregnant women during the first prenatal visit and a repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks of gestation, as required.

d) **Syphilis screening** for all pregnant women.

e) **Interventions to support breast feeding** during and after birth.

f) **Tobacco use counseling.**

g) **Hepatitis B virus (HBV) screening** for pregnant women.

7. **Counseling Preventive Services which include:**

a) **Counseling related to BRCA screening of women** is covered when the woman is referred by her PCP or Participating Health Care Provider 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** as determined by the PCP or Participating Health Care Provider for sexually active adolescents and adults.

e) **Tobacco use counseling** which includes cessation interventions for those using tobacco.

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 Participating Provider and presented to a Participating Pharmacy or Participating Mail Order Pharmacy for coverage by the Plan.

9. Pulmonary Function Tests (PFTs).

11. GENERAL PROVISIONS.

1. This Amendment shall be effective for the Benefit Period beginning on or after January 1, 2013.

2. If any provisions of the Subscription Certificate are inconsistent with the terms of this Amendment, the terms of this Amendment shall prevail.

3. Except as herein amended, the Subscription Certificate shall remain in full force and effect.

Duane E. Davis, M.D.
President, Chief Executive Officer
Geisinger Health Plan
100 North Academy Avenue
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George A. Schneider, CPA
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GEISINGER HEALTH PLAN

AMENDMENT TO GEISINGER HEALTH PLAN GROUP HMO SOLUTIONS SUBSCRIPTION CERTIFICATE

As required by the Patient Protection and Affordable Care Act of 2010 ("PPACA") (commonly known as Health Care Reform), the following amendments are necessary to provide coverage of the Women's Health and Well-Being Preventive services.

I. The **GEISINGER HEALTH PLAN GROUP HMO SOLUTIONS SUBSCRIPTION CERTIFICATE ("Certificate") (M-150-841-F Rev. 4/10)** to which this Amendment is attached, is revised as follows**:**

A. **Section 3.13.1, Contraceptive Implanted Devices** is deleted from the Certificate in its entirety.

B. **Section 3.13.2, Cost Sharing** is deleted from the Certificate in its entirety and replaced with the following:

3.13.2 **Cost Sharing.** Implanted devices for purposes of drug delivery are covered subject to the implanted device Coinsurance 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 not subject to the implanted device Coinsurance.

C. Section **4.15, Drugs and Devices for Purposes of Contraception,** is deleted from the Certificate in its entirety and replaced with the following:

4.15 **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 2, Preventive Services** and an **Outpatient Prescription Drugs Rider** if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.

D. Section **4.61.22, Specifically Listed Items, Devices and Equipment**, is amended to delete reference to:

a) Breast pumps.

E. The Certificate and all Amendments prior to the date of this Amendment (if applicable) are amended to include the following **Exhibit 2, Preventive Services**.

Exhibit 2
Preventive Covered Services

The following preventive health care Covered Services are covered under this Plan with no Member 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 Participating Provider as set forth in Section 3.1.1 of this Certificate or upon Referral from a Participating Provider.

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),

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;

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 Plan.

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 PCP or OB/GYN Participating 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 12th through 16th week of gestation or during the first prenatal visit, if such a visit is later than the 12th – 16th 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 Plan.

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 Participating Provider and presented to a Participating Pharmacy.

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 PCP or OB/GYN Participating 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.

II. AMENDMENT TO THE GEISINGER HEALTH PLAN GROUP HMO SOLUTIONS OUTPATIENT PRESCRIPTION DRUG RIDERS

The Geisinger Health Plan, Group HMO Solutions Outpatient Prescription Drug Riders to which this Amendment is attached are revised as follows.

A. Rider Section **2.4** or **3.4** (depending on the applicable Drug Rider), which states: "The following over-the-counter medications are covered when an oral or written prescription for the item is provided by a Participating Health Care Provider and the item is obtained from a Participating Pharmacy or Participating Mail Order Pharmacy:" is amended to include the following:

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

B. Rider Section **4.2.2, 5.2.2** or **6.2.2** (depending on the applicable Drug Rider)**, Contraceptive Devices** is deleted from the Rider's Exclusions and replaced with the following**:**

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.

C. Rider Section **4.3**, **5.3** or **6.3** (depending on the applicable Drug Rider), is deleted from the Rider's Exclusions and replaced with the following:

Experimental drugs and/or devices, including those labeled "Caution-limited by Federal law to Investigational Use," non-FDA approved drugs and/or devices, FDA approved drugs and/or devices for investigational indications or for non-FDA approved uses or at investigational doses and drugs and/or devices found by the FDA to be ineffective.

D. Rider Section **4.6, 5.6** or **6.6** (depending on the applicable Drug Rider), which states: "Over-the-counter drugs and other items available without a prescription, whether provided with or without a prescription, including but not limited to aspirin, oxygen, cosmetics, medicated soaps, food supplements, vitamins, bandages and spermicidal agents (except for those over-the-counter medications listed in Section 2.4 of this Rider)." is amended to remove **spermicidal agents** from the exclusion.

III. GENERAL PROVISIONS

1. This Amendment shall be effective for the Benefit Period beginning on or after August 1, 2012.

2. If any provisions of the Certificate are inconsistent with the terms of this Amendment, the terms of this Amendment shall prevail.

Jean Haynes
President, Chief Executive Officer
Geisinger Health Plan
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Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

Group Subscription Certificate for Solutions

(This Subscription Certificate
also applies to Small Business)
(Rev. 4/10)

M-150-841-F Rev. 4/10

GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, Pa. 17822-3220

HEALTH MAINTENANCE ORGANIZATION
Group Subscription Certificate
Solutions

Thank you for choosing Geisinger Health Plan.

Geisinger Health Plan (the Plan) is a not-for-profit corporation located in Danville, Pennsylvania that owns and operates a health maintenance organization (HMO). An HMO arranges for specified health services to its Members on a prepaid basis.

Solutions is a plan that provides traditional HMO benefits with fixed Copayments for primary care and Specialist care office visits, periodic health assessments and emergency care visits. Most other services are subject to a Deductible which must be met each Benefit Period before your Coinsurance applies. The Coinsurance is a set percentage of the amount the Plan has agreed to reimburse a provider for Covered Services.

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, 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, Copayment, Deductible and Coinsurance amounts expected for Covered Services, including the maximum limit charged to a Member within a Benefit Period and Riders;
5. Enrollment Application, which is the Subscriber's written request for enrollment;
6. The Group Master Policy, which is an agreement between the Plan and a Group for coverage arranged by the Plan to individuals eligible to receive health benefits through their employer; and
7. The Member's Enrollment Letter.

The Plan issues these documents in accordance with the terms of a Certificate of Authority awarded by the Pennsylvania Departments of Health and Insurance, pursuant to the Pennsylvania Health Maintenance Act of 1972, as amended. Together, the Certificate and any Amendments, Riders (if any), Schedule of Benefits, Enrollment Application to enroll in the Plan and the Enrollment Letter constitute the entire agreement between the Subscriber named on the Schedule of Benefits and the Plan. 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 Plan, 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 Plan will provide all Members and prospective Members with any of the following information. Please call the Customer Service Team for:

- a list of the names, business addresses and official positions of the membership of the Plan's Board of Directors;
- the procedures adopted to protect the confidentiality of medical records and other enrollee information;
- a description of the credentialing process for Health Care Providers;
- a list of the Participating Health Care Providers affiliated with hospital Participating 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 Participating 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 enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee;
- a description of the procedures followed by the Plan to make decisions about the experimental nature of individual drugs, medical devices or treatments;
- a summary of the methods used by the Plan to reimburse for health care services; and/or
- a description of the procedures used in the Plan's quality assurance program.

Please take the time to review your Group Subscription Certificate carefully for a full description of Covered Services and exclusions, as well as the Complaint and Grievance process that is available to you as a Member of the Plan.

For help and information: Members should call the Customer Service Team at the telephone number listed 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 Plan. Members may also write to Geisinger Health Plan, Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3229.

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.

IN WITNESS WHEREOF,
Geisinger Health Plan
has duly executed this Certificate

Jean Haynes
President, Chief Executive Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

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SECTION 1. DEFINITIONS

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

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

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

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

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

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

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

1.7 Certified Review Entity (CRE) means an independent utilization review entity, not directly affiliated with the managed care plan, certified pursuant to §9.602 of Title 28, PA Code to perform an External Grievance Appeal Review.

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

1.9 Coinsurance is a form of Cost Sharing (indicated as a percentage amount on the Schedule of Benefits) which requires the Member to pay a specified portion of the cost of a Covered Service.

1.10 Coinsurance Maximum means the maximum dollar amount in the form of Coinsurance that a Member or Family Unit will be required to pay for services, as set forth on the Schedule of Benefits. The Coinsurance Maximum does not include the following:

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

(iv) amounts above the Lifetime Benefit Maximum as set forth on the Schedule of Benefits; and
(v) amounts for non-Covered Services.

This means that the Member**,** not the Plan, will be responsible for payment of all these amounts noted above, even if the Coinsurance Maximum has been reached. The Coinsurance Maximum applies to each Member or Family Unit subject to any family Coinsurance Maximum set forth on the Schedule of Benefits.

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

1.12 **Complaint** is a dispute or objection by a Member regarding a Participating Health Care Provider, or the coverage (including exclusions and non-covered benefits), operations or management policies of the Plan, that has not been resolved by the Plan and has been filed with the Plan or the Department of Health or the Insurance Department of the Commonwealth. The term does not include a Grievance.

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

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

1.15 **Covered Service** means:

a) a Medically Necessary (unless otherwise indicated) service or supply specified in this Certificate for which benefits will be provided pursuant to the terms of the Certificate; or
b) any Medically Necessary Supplemental Health Services as set forth in any Riders supplementing this Certificate.

Services which are listed as **NOT COVERED** in this Certificate or in any Riders supplementing this Certificate are **NOT COVERED** by this Plan regardless of whether they are deemed Medically Necessary.

1.16 **Creditable Coverage** means the length of time an enrollee had previous continuous health coverage which was not interrupted by a sixty-three (63) day break in coverage. This coverage may be credited against, and reduce the length of, any Pre-Existing Condition exclusion that may be applied by the Plan in accordance with HIPAA.

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

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

1.19 **Deductible** means a specified dollar amount for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the Plan will assume any liability for

all or part of the cost of Covered Services. The Deductible applies to each Member subject to any Family Deductible as set forth on the Schedule of Benefits. Unless otherwise specified, the Deductible must be met every Benefit Period before a Coinsurance applies. Certain Supplemental Health Services may have a separate Deductible, as set forth on the Schedule of Benefits and the terms of the applicable Rider. Copayment amounts do not accrue toward satisfaction of any Deductible amounts.

1.20 **Designated Behavioral Health Benefit Program** means a program in which the Plan manages behavioral health services (including inpatient and outpatient mental health and Substance Abuse care). The Member must access care directly through the Designated Behavioral Health Benefit Program for coverage, subject to limitations or exceptions set forth in this Certificate or in any applicable Riders.

1.21 **Designated Transplant Facility** is a facility that has entered into an agreement with the Plan, the Plan's transplant subcontractor or national organ transplant network to provide Transplant Services when a transplant service as set forth in Section 3.29 of this Certificate is Medically Necessary for a Member. The Designated Transplant Facility is determined by the Plan or the Plan's transplant subcontractor and may or may not be located in the Service Area.

1.22 **Durable Medical Equipment (DME)** means equipment which is designed to serve a medical purpose and which is not generally useful to a person in the absence of illness or injury, is able to withstand repeated use, is not a disposable or single patient use and is required for use in the home.

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

a) placing the health of the Member, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy;
b) serious impairment to bodily functions; or
c) serious dysfunction of any bodily organ or part.

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

1.24 **Enrollment Application** refers to the forms completed by the applicant for enrollment purposes.

1.25 **Enrollment Letter**. The Enrollment Letter is a letter sent by the Plan to the Member as notification that they are an enrolled Member under the Geisinger Health Plan Solutions HMO. The Enrollment Letter sets forth the Member's effective date of coverage under the Plan.

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

a) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use (however, approval by the FDA or other federal regulatory agency does not imply that the technology is automatically considered by the Plan to be Medically Necessary or as being the accepted standard of care); or not

identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Health Care Provider as being investigational, experimental, research based or educational; or

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

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

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

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

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

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

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

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

1.27 **Family Coverage** means the health benefits coverage provided under this Certificate for a Subscriber and one or more Family Dependents who are Members under the same Certificate.

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

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

b) who is enrolled under this Certificate; and

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

d) a Family Dependent is also a Member as defined in Section 1.44 of this Certificate.

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

1.30 **Grievance** is a request by a Member, Participating Provider or Health Care Provider (with the written consent of the Member) to have the Plan or a Certified Review Entity (CRE) reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. If the Plan is unable to resolve the matter, a Grievance may be filed regarding the decision that does any of the following:

a) disapproves full or partial payment for a requested health service;

b) approves the provision of a requested health care service for a lesser scope or duration than requested;

c) disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

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

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

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

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

a) limiting exclusions for Pre-Existing Conditions (as defined under HIPAA);
b) prohibiting discrimination against employees and dependents based on their health status;
c) guaranteeing renewability and availability of health coverage to certain employers and individuals;
d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and
e) regulating the use and disclosure of protected health information.

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

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

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

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

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

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

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

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

a) establishing the Plan of Care;

b) periodically reviewing and updating the Plan of Care;

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

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

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

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

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

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

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

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

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

1.35.8 **Routine Home Care** means a level of intermittent and part-time care provided in

accordance with a Member's Plan of Care and rendered by qualified professionals in the Member's home. Such care shall include nursing services, social services, physical therapy, occupational therapy, speech pathology, and counseling and support services for both the Member and the Member's family.

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

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

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

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

1.39 Level 1 Bariatric Center of Excellence is an institution which meets certain accreditation standards and is designated by either the American Society of Bariatric Surgery or American College of Surgeons as a Level 1 Bariatric Center of Excellence.

1.40 Lifetime Benefit Maximum means the maximum amount of Covered Services that the Plan will cover during a Member's lifetime under this Certificate, as set forth on the Schedule of Benefits. This could be expressed in dollars, number of days or number of services.

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

1.42 Medical Director means the licensed physician designated by the Plan to direct the medical and scientific aspects of the Plan, and to monitor and oversee the quality and appropriateness of managed health services.

1.43 Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a) appropriate for the symptoms and diagnosis and treatment of the Member's condition, illness, disease or injury;
b) provided for the diagnosis and the direct care and treatment of the Member's condition, illness, disease or injury;
c) in accordance with current standards of good medical treatment practiced by the general medical community;
d) not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

1.44 Medicare means the programs of health care for the aged and disabled established by Title

XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

1.45 **Member** means an individual eligible to receive Covered Services or benefits under the terms of this Certificate either as the Subscriber or an eligible enrolled Family Dependent.

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

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

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

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

1.50 **Participating Health Care Provider or Participating Provider** means a Health Care Provider that has an agreement with the Plan to provide Covered Services to Members under this Certificate and pursuant to which such Health Care Provider is a part of the Plan's Network, except as defined in Section 2.5.2 of this Certificate.

1.51 **Pre-Existing Condition** means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present within one hundred eighty (180) days immediately prior to the effective date of coverage under a group health plan.

1.52 **Primary Care Physician** means a person licensed in the Commonwealth of Pennsylvania or another state as applicable, as a doctor of medicine or osteopathy (or his/her designee) who has an agreement with the Plan to coordinate and provide initial and basic care to Members and initiates their Referral for Specialist care.

1.53 **Prior Authorization** means the process by which Covered Services are reviewed by the Plan prior to the services being performed. This review is based on Medical Necessity, eligibility and benefit availability at the time the Covered Services are to be provided**.** This process is initiated by the Participating Provider unless otherwise indicated in the Certificate or Rider as being the responsibility of the Member.

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

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

1.56 **Referral** is the means set forth in Section 2.4 of this Certificate by which a Member's Primary Care Physician or their designee directs a Member to be evaluated and/or treated by another Participating Provider, prior to such services being provided.

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

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

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

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

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

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

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

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

1.65 **Urgent Care** means any Covered Service provided to a Member in a situation which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency Service as it allows the Member to consider alternative settings of care.

SECTION 2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES

2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES.

2.1 Satisfactory Relationships. Members shall maintain satisfactory relationships with Primary Care Physicians and all other Participating Providers.

2.2 Relationship of Providers to the Plan. Each Primary Care Physician and Participating Provider is:

a) an independent contractor;

b) the employee of an independent contractor; or

c) subcontracted through a provider organization over whom the Plan does not exercise control nor the right to control the conduct and performance of services to Members under this Certificate.

Primary Care Physicians and all other Participating Providers are not servants, employees or agents, actual or apparent, of the Plan.

2.3 Choice of Primary Care Physician. Upon enrollment, the Subscriber shall choose a Primary Care Physician for himself and for each enrolled Family Dependent. The Provider List indicates the Primary Care Physicians who are part of the Plan's Network.

A Subscriber who fails to choose a Primary Care Physician will be assigned one for himself and each enrolled Family Dependent.

2.3.1 **Changing a Primary Care Physician**. A request for change of the Member's Primary Care Physician may be made by contacting a Customer Service Team representative or submitting a change form which may be obtained from the Subscriber's employer or the Member's Primary Care Physician. Changing the Member's Primary Care Physician is, at all times, subject to the availability of the Primary Care Physician.

2.3.2 **Restrictions on the Selection of a Primary Care Physician.** A Subscriber may not select a Primary Care Physician who is the Member's spouse, child, parent, grandparent, aunt, uncle, niece, nephew or sibling. If a Subscriber is also a Primary Care Physician, he or she may not select himself or herself as a Primary Care Physician for their own treatment under the Plan.

2.4 Members Access to Covered Services. To be covered under the terms of this Certificate, all Covered Services must be delivered, prescribed or referred in advance by the Member's Primary Care Physician except those identified in Section 2.4.2 of this Certificate.

2.4.1 **Required Referral(s).** All Covered Services not provided by the Member's Primary Care Physician, except those identified in Section 2.4.2 of this Certificate require a Referral as follows:

2.4.1.1 **Primary Care Physician Referral.** Referrals for Covered Services that are not available by the Member's Primary Care Physician, but which are available through another Participating Provider, must be completed in advance by each Member's Primary Care Physician unless otherwise specified as requiring Plan approval. In the event a Member changes their

Primary Care Physician, the Member must contact the new Primary Care Physician and request a review of open Referrals.

The new Primary Care Physician may approve such Referrals for Covered Services if deemed appropriate.

2.4.1.2 **Prior Authorization.** Prior Authorization must be obtained by the Participating Provider or the Member for Covered Services that are not available through a Participating Provider and/or for certain procedures and services designated by the Plan. This process is initiated by the Participating Provider unless otherwise indicated in the Certificate or Rider as being the responsibility of the Member.

a) Members may call the Customer Service Team at the number on the back of their Identification Card for an explanation of what Covered Services require Prior Authorization.

2.4.1.3 **Standing Referrals to Specialists.** The Member's Primary Care Physician may issue a Standing Referrals for Covered Services for a Member with a life-threatening, degenerative or disabling disease or condition if the Member meets the following established standards:

a) The Member must request an evaluation to determine the presence of a life-threatening, degenerative or disabling disease or condition.

b) Upon meeting the Plan's standards, the Member may receive, in consultation with the Member's Primary Care Physician:
   i) a standing Referral to a Specialist with clinical expertise in treating the disease or condition; or
   ii) the designation of a Specialist to provide and coordinate the Member's primary and specialty care.

c) Such Referral shall be pursuant to a treatment plan approved by the Plan, in consultation with the Primary Care Physician, the Member and, as appropriate, the Specialist.

In the event a Member is a Primary Care Physician, the Member may not issue a standing referral for himself/herself.

2.4.2. **Direct Access by Member.** The following Covered Services may be obtained directly by the Member without a Referral from the Member's Primary Care Physician.

2.4.2.1 **Direct Access to Obstetrical and Gynecological Services.** Female Members may select a Participating Health Care Provider to obtain maternity and gynecological Covered Services, including Medically Necessary and appropriate follow-up care and diagnostic testing relating to maternity and gynecological care, without a Referral from the Member's Primary Care Physician. Covered Services shall be within the scope of practice of the selected Participating Health Care Provider.

2.4.2.2 **Access to Mental Health and Substance Abuse Services.** Members may select a Provider who participates with the Plan's Behavioral Health Benefit Program to obtain Covered Services for mental health and Substance Abuse including Medically Necessary and appropriate follow-up care and

diagnostic testing related to mental health or Substance Abuse care without a Referral from the Member's Primary Care Physician.

2.4.2.3 **Emergency Services**. Members may access Emergency Services as set forth in Section 3.7 of this Certificate.

2.4.2.4 **Primary Care Physician Self-Referral Restriction.** In the event a Member is a Primary Care Physician, the Member may not issue a Referral for a Covered Service for himself/herself.

2.5 Continuity of Care.

2.5.1 **Transitional Period.** A new Member, at the Member's option, may notify the Plan of the Member's desire to continue an ongoing course of treatment for Covered Services with a Non-Participating Provider to the extent such services are not covered by the Member's previous health insurance plan, in accordance with the following:

a) for a transitional period of up to sixty (60) days from the effective date of enrollment with the Plan. This period may be extended if it is determined to be clinically appropriate by the Plan, Member and Non-Participating Provider; or

b) if the Member is in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery.

Any Covered Services provided by a Non-Participating Provider under this Section shall be covered by the Plan under the same terms and conditions for Participating Providers. If the Non-Participating Provider does not accept the Plan's terms and conditions, the service will not be covered by the Plan.

2.5.2 **Termination of Participating Provider or Participating Practitioner Without Cause.** The following definitions **apply only** to Section 2.5.2 of the Certificate:

Participating Provider means a hospital, facility or institution, licensed certified or otherwise regulated under the laws of the Commonwealth of Pennsylvania, that has an agreement with the Plan to provide Covered Services to Members under this Certificate.

Participating Practitioner means a health care professional, licensed, certified or otherwise regulated under the laws of the Commonwealth of Pennsylvania, that has an agreement with the Plan to provide Covered Services to Members under this Certificate.

2.5.2.1 **Termination Initiated by the Plan**. If the Plan terminates the contract of a Participating Provider or Participating Practitioner for reasons other than cause, a Member, at the Member's option, may continue an ongoing course of treatment with a terminated Participating Provider or Participating Practitioner:

a) for a transitional period of up to sixty (60) days from the date the Member was notified by the Plan of the termination or pending termination of a Participating Provider, or ninety (90) days from the date the contract of a Participating Practitioner was terminated. This

period may be extended if determined to be clinically appropriate by the Plan; or

b) if the Member is in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery.

Any Covered Services provided under this Section shall be covered by the Plan under the same terms and conditions for Participating Providers and Participating Practitioners. If the Non-Participating Provider or non-Participating Practitioner does not accept the Plan's terms and conditions, the service will not be covered by the Plan.

2.5.2.2 **Termination Initiated by the Participating Practitioner.** If the Participating Practitioner terminates his contract with the Plan for reasons other than cause, a Member at the Member's option, may continue an ongoing course of treatment with a Participating Practitioner:

a) for a transitional period of up to ninety (90) days from the date the contract of the Participating Practitioner was terminated. This period may be extended if determined to be clinically appropriate by the Plan; or

b) if the Member is in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery.

Any Covered Services provided under this Section shall be covered by the Plan under the same terms and conditions for Participating Practitioners. If the non-Participating Practitioner does not accept the Plan's terms and conditions, the service will not be covered by the Plan.

2.5.3 **Termination of Participating Provider with Cause.** If the Plan terminates the contract of a Participating Provider for cause, including breach of contract, fraud, criminal activity or posing a danger to a Member or the health, safety or welfare of the public as determined by the Plan, the Plan shall not be responsible for Covered Services provided by the terminated Participating Provider to the Member following the date of termination.

2.5.4 **Selection of Primary Care Physician.** If the Plan terminates the contract of a Primary Care Physician, the Member served by that Primary Care Provider will be notified by the Plan and will have the opportunity to choose another Primary Care Physician, subject to the availability of the Primary Care Physician.

2.6 Refusal To Accept Recommended Treatment/and Advance Health Care Directives. A Member has the right to participate in planning his own treatment and to give his informed consent before the start of any procedure or treatment. A Member also has the right to formulate an Advance Health Care Directive and/or appoint a surrogate to make health care decisions on his behalf to the extent permitted by law, should the Member become incapacitated. Any Member may, for personal reasons, refuse to accept one or more drugs, treatments or procedures recommended by a Participating Provider. A Member has the option to refuse to accept the recommended drug, treatment or procedure of a Participating Provider, either:

a) verbally;

b) through an Advanced Health Care Directive; or
c) through a properly appointed surrogate.

2.7 Medical Records-Confidentiality. A Member's medical record and other information, including information relating to HIV/AIDS, Substance Abuse and behavioral health treatments, received by the Plan concerning Members will be kept confidential to the extent required by law. Such records and other information will be disclosed by the Plan only as required by law or court order, upon written authorization by a Member, or in connection with: verification of a Member's coverage, including coordination of benefits, facilitation of claims payment, and care coordination; exchange of information between the Plan and its agents/contractors, Primary Care Physicians and other providers for bona fide medical purposes or in connection with a Member's Complaint or Grievance; compilation of demographic data; internal and external audits; the conduct of the Plan's quality improvement and medical management programs; and general administration of this Certificate and the Plan.

2.7.1 **Cost of Medical Records.** The cost of providing medical records to the Plan, a Primary Care Physician, or a Health Care Provider is a covered benefit if the records are related to a Covered Service.

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

a) Emergency admission to a Non-Participating Provider will be managed through the Plan's out-of-Network retrieval process. The Member may be offered transfer to a facility Participating Provider when determined appropriate by the Plan.

b) Planned and urgent inpatient admissions and certain designated services and procedures require Prior Authorization.

c) The Plan's case management nursing staff is available to assist Members who require transplants, have catastrophic disease or injury, request services outside the Network, when temporarily outside the Service Area and require Urgent Care, can benefit from individualized attention to coordinate their needs, or are otherwise recommended for case management.

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

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

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

The Plan's medical management policies and procedures comply with National Committee for Quality Assurance standards related to utilization.

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 this Certificate. The fact that a Provider prescribed, ordered, recommended or approved a medical service or supply does not automatically constitute coverage by the Plan.

Please be advised that the benefits set forth in this Section 3 and in any Riders for supplemental Health Services, if any such Riders have been purchased, are subject to the Copayments, Coinsurance, Benefit Limits and Lifetime Benefit Maximums that are specifically set forth on the Schedule of Benefits as well as the individual Benefit Limits set forth in this Section 3, any Riders and on the Schedule of Benefits.

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 a Covered Service from a Participating Provider (Section 3.1.1), when services from a Non-Participating Provider are Covered Services (Section 3.1.2), coverage parameters regarding the Covered Services (Sections 3.1.3.), Covered Service Location Cost Sharing (Section 3.1.4); Supplemental Health Services (Section 3.1.5) and second opinion coverage (Section 3.1.6).

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, Member's Cost Sharing or how the Covered Service may be obtained by the Member.

3.1.1 **Covered Services from a Participating Provider**. A Member may access Covered Services without a Referral from the following Participating Providers:

a) the Member's Primary Care Physician;

b) the Member's obstetrical or gynecological Participating Health Care Provider;

c) the Member's mental health or Substance Abuse Participating Health Care Provider (as detailed in Sections 3.16 and 3.17 of this Certificate); and/or

d) Health Care Providers rendering Emergency Services as set forth in Section 3.7 of this Certificate.

In all other situations, Services obtained from a Participating Provider require a Referral.

3.1.2 **Covered Services from a Non-Participating Provider.** The following are exceptions where Covered Services may be obtained from a Non-Participating Provider within or outside of the Member's Service Area:

a) Emergency Services as set forth in Section 3.7 of this Certificate;

b) Urgent Care as set forth in detail in Section 3.31 of this Certificate;

c) when the Member obtains Prior Authorization because the Member's medical condition requires Covered Services which cannot be provided by a Participating Provider or cannot be provided within the Service Area; or

d) for Covered Services under this Certificate in accordance with the continuity of care provisions for new and existing Members as provided in Section 2.5 of this Certificate.

3.1.3 **The Plan's Coverage of Covered Services**:

3.1.3.1 **Coverage**. The fact that the Member's Primary Care Physician or any other Participating Provider may prescribe, order, recommend or approve a medical service or supply does not automatically constitute coverage by the Plan. 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.

3.1.3.2 **Coverage of Service when a Participating Provider's Relationship is Terminated with the Plan.** In the event a Member is receiving Covered Services from a Participating Provider whose participation with the Plan has been terminated, the Plan will provide payment for Covered Services under this Certificate in accordance with continuity of care provisions set forth in Section 2.5 of this Certificate.

3.1.4 **Covered Service Location Cost Sharing**. Certain Covered Services (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.

3.1.5 **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, 3.1.3 and 3.1.4 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.

3.1.5.1 **Point of Service Rider Exception.** If a Member has a Point of Service Rider supplementing their Certificate, the following may differ from the terms and conditions set forth in this Certificate:

a) the terms and conditions regarding how a Member may access a Participating Provider differ from those listed in Section 3.1.1 of this Certificate;

b) the Cost Sharing terms and allocations for the benefits may differ from those set forth in this Certificate; and

c) there are exclusions listed on the Point of Service Rider which are in addition to those listed in Section 4 of this Certificate.

Please refer to the Point of Service Rider for specific information on how benefits may be obtained by the Member and Cost Sharing terms.

3.1.6 **Second Opinion Coverage**: A second opinion relating to a Covered Service is covered when received from a Participating Provider upon Referral by the Primary Care Physician or from a Non-Participating Provider when the Member obtains Prior Authorization.

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 3.22 of this Certificate.

3.2 Cardiac Rehabilitation. Outpatient Cardiac rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period when the service is obtained from a Participating Provider.

3.3 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 when provided in accordance with an approved treatment plan established and provided through a Participating Provider. The Plan reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.

3.3.1 **Diabetic Medical Equipment.** The Plan 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.

3.3.2 **Diabetic Foot Orthotics.** The Plan will cover diabetic foot orthotics when provided by a Participating Provider.

3.3.3 **Prescription Drugs.** The Plan will cover insulin and oral pharmacological agents for controlling blood sugar as prescribed by a Participating Provider. Disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips) shall be covered. Prescription drugs under this section are subject to the prescription drug Cost Sharing as set forth on the Schedule of Benefits.

3.3.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered upon Referral by the Member's Primary Care Physician and provided at an approved Plan program site under the supervision of a Participating 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 Member's Primary Care Physician 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 Member's Primary Care Physician or a Participating Provider.

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

3.4 Diagnostic Services. Diagnostic tests, services, and materials, including diagnostic radiology and imaging, laboratory tests and electrocardiograms, are covered when ordered in advance by a Participating Provider as set forth in Section 3.1.1 of this Certificate. The diagnostic testing must be related to services within the Participating Health Care Provider's scope of care.

3.5 Disease Management Programs. The Plan offers programs focused on clinical health conditions including education and management (in conjunction with the Member's Primary Care Physician). Participation in a Plan disease management/care management program may include coverage for certain services that would not otherwise be provided for under this Certificate.

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

3.6.1 **Definitions.** For the purposes of this Durable Medical Equipment, Orthotic Devices and Prosthetic Devices Section and Section 4.61 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 DME is contingent upon a Member's Compliance in using the equipment as indicated in the course of treatment as determined by the Plan.

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 DME.

d) **Standard** means possessing qualities or attributes which are determined by the Plan to be: (i) Medically Necessary (in the absence of Plan criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations); (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available.

3.6.2 **Durable Medical Equipment (DME) and Related Supplies.** Upon Prior Authorization, the Plan will cover the cost of renting, or at its option, purchasing Medically Necessary Standard DME and Related Supplies when prescribed in advance by a Participating 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 Participating Provider. The Plan reserves the right to recover any DME purchased by the Plan 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 Plan. Coverage of DME is subject to the Exclusions set forth in Section 4.61 of this Certificate.

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

3.6.2.2 **Manufacturer.** The Plan reserves the right to restrict the manufacturer of Standard DME covered under this Certificate. Such restriction is subject to change by the Plan without the consent or concurrence of the Member except as provided for herein.

3.6.3 **Orthotic Devices**. The Plan will pay for the purchase of Standard Orthotic Devices when prescribed in advance by a Participating Provider or when approved in advance by the Plan. Standard Orthotic Devices must be obtained from a Participating Provider unless authorized in advance by the Plan. Coverage of Orthotic Devices is subject to the Exclusions set forth in Section 4.61 of this Certificate.

3.6.4 **Prosthetic Devices**. The Plan will pay for the purchase of Standard Prosthetic Devices, or the replacement of component parts or modification of a Standard Prosthetic Device when prescribed in advance by a Participating Provider or when approved in advance by the Plan. Standard Prosthetic Devices must be obtained from a Participating Provider unless authorized in advance by the Plan. This benefit applies to: (i) a new Standard Prosthetic Device; and (ii) a new Standard Prosthetic Device or replacement of an existing Standard Prosthetic Device every five (5) years. 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. Coverage of Prosthetic Devices is subject to the Exclusions set forth in Section 4.61 of this Certificate.

3.6.4.1 **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 Standard Prosthetic Device occasioned by the Member's growth, in addition to the initial purchase of such a device.

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

3.6.5 **Durable Medical Equipment and Prosthetic Devices Cost Sharing Benefit Limits**. The Benefit Limits and Cost Sharing for DME and Prosthetic Devices are set forth on the Schedule of Benefits.

3.7 Emergency Services. 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. Emergency Services do not require prior approval by the Plan. 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 Participating

Provider, the Plan 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 Participating Provider, subject to Sections 3.7.1(d) and 3.7.2.

3.7.1 **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 Plan 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 Plan of the Emergency Services provided by the Emergency Services Health Care Provider.

d) Medically Necessary follow-up services obtained from a Participating Provider after the initial response to an emergency are not Emergency Services, and must be authorized in advance by the Member's Primary Care Physician, obstetrical or gynecological Participating Health Care Provider (for services within their scope of care) or a Designated Behavioral Health Benefit Program Provider.

e) Medically Necessary follow-up services obtained from a Non-Participating Provider after the initial response to an emergency are not Emergency Services. The Member must obtain Prior Authorization prior to accessing these services.

f) For the emergency treatment of sound, natural teeth please refer to Section 3.19, Oral Surgery**.** The need for these services must result from an accidental injury (not chewing or biting).

3.7.2 **Non-Participating Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Participating Provider, the Plan 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 Participating Provider. However, Emergency Services provided by Non-Participating Providers will be covered as if provided by a Participating Provider only until the Plan determines the Member's condition has stabilized and the Member's care can be transferred to a Participating Provider without suffering detrimental consequences or aggravating the Member's condition.

3.7.3 **Cost Sharing.** Emergency Services are subject to the emergency room Copayment specified on the Schedule of Benefits. The Copayment 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 are satisfied.

The Primary Care Physician Copayment shall apply in lieu of the emergency room Copayment when a Member has been referred to an emergency department by his Primary Care Physician for Covered Services, **AND** the Covered Services would have been provided in the Primary Care Physician's office but the physician's office could not provide access during normal working hours.

3.8 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 Participating Provider.

3.9 Foot Care Services. Foot care and treatment for disease, injury and related conditions of the feet are covered if provided by or upon Referral by the Member's Primary Care Physician, except as set forth in Section 4.20 of this Certificate.

3.10 Home Health Care. Upon Prior Authorization, home health services is covered only in the event a Member is homebound except as provided in Section 3.10.4. 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 3.15.

If the Member has an approved treatment plan established by a home health agency and a physician (both of which must be Participating Providers), then the following home health care services are covered:

3.10.1 **Skilled Nursing Personnel.** Skilled nursing visits in the home that are provided by skilled nursing personnel, who are Participating Providers, and who are supervised by physician Participating Providers, are covered when ordered by the Member's Primary Care Physician or Participating Provider upon Referral by the Primary Care Physician and Prior Authorization by the Plan.

3.10.2 **Physician Services.** Care in the home by a physician is covered when provided by the Member's Primary Care Physician or a Participating Provider upon Referral by the Member's Primary Care Physician.

3.10.3 **Other Health Care Personnel.** Medical care in the home is covered when the care is given by Health Care Participating Providers (including but not limited to, speech, physical and occupational therapists) under the supervision of physician Participating Providers. This care is covered when there is Prior Authorization by the Plan and the care is ordered by the Member's Primary Care Physician or Participating Provider upon Referral by the Primary Care Physician. Home health care services are also, subject to any specific benefit limitations set forth in this Section 3 of the Certificate.

3.10.4 **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.

3.11 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) obtained upon Prior Authorization by the Plan when prescribed by a Primary Care Physician, or a physician Participating Provider upon Referral by a Member's Primary Care Physician;

b) directly related to the Terminal Illness of a Member; and

c) rendered in accordance with the Member's Plan of Care and through a Participating Provider.

3.11.1 **Hospice Benefit Election.** The Member shall have the option to elect to receive the Plan's Hospice benefit 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 care solely for reducing the intensity of and management of the Member's Terminal Illness;

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

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

3.11.2 **Limitations.** The maximum amount which the Plan will pay for all Hospice benefits provided hereunder to any one (1) Member is set forth on the Member's Schedule of Benefits. Covered Services provided which are unrelated to the Member's Terminal Illness shall not be covered under the Plan's Hospice benefit, but shall be covered as set forth in the applicable provisions of the Member's Certificate.

3.12 Hospital and Ambulatory Surgical Center Services.

3.12.1 **Benefits.** Hospital benefits may be provided at a hospital Participating 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 Plan), general nursing care and the following additional facilities, services and supplies as prescribed through a Participating Provider (or another physician in response to an emergency): 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 this Certificate in Section 3.24 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.

3.12.2 **Prior Authorization.** Inpatient hospital admissions require Prior Authorization.

3.12.3 **Duration of Benefit**. Except for mastectomy Covered Services as set forth in Section 3.14 of this Certificate, inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the Plan and not determined to be Custodial, Convalescent or Domiciliary Care.

3.13 Implanted Devices. The following implanted devices are covered when a) provided by the Member's Primary Care Physician, a Specialist upon Referral by the Primary Care Physician or an obstetrical or gynecological Participating Health Care Provider and b) when the implanted devices are within such Participating Provider's scope of practice: implanted devices for purposes of drug delivery or contraception; 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.

3.13.1 **Contraceptive Implanted Devices.** Implanted devices for the purpose of contraception are covered only if the Member has an Outpatient Prescription Drug Rider with Contraceptive coverage listed on the Schedule of Benefits as being in place with the Plan.

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

3.14 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;

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

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

3.15 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. 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 Participating Provider services shall be covered only if provided in a hospital Participating Provider or a licensed free-standing birthing center Participating Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.18 below.

3.15.1 **Cost Sharing.** The office visit Copayment applies only to the first prenatal visit (after pregnancy has been confirmed) and will not apply to subsequent prenatal or postpartum visits. Each covered day of a hospital stay and related physician services for maternity are subject to the inpatient hospital Coinsurance specified on the Schedule of Benefits, as well as any other applicable Cost Sharing specified on the Schedule of Benefits. Postpartum home health care visits within forty-eight (48) hours for early discharges are not subject to any Cost Sharing under this Section.

3.16 **Mental Health and Substance Abuse Services**.

NOTE: *To determine if this Section 3.16 applies to you, please refer to the bottom of your Schedule of Benefits where you will be directed to the applicable Mental Health and Substance Abuse Services section of this Certificate.*

3.16.1 **Mental Health Services (Applicable to Members of Groups with fifty (50) or less Employees).** All mental health Covered Services must be obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional who participates with the Plan's Designated Behavioral Health Benefit Program. A Member may access mental health Covered Services in the following manner:

a) as a hospital inpatient as set forth in Section 3.21.2 (b) of this Certificate;

b) as an outpatient for a maximum of thirty (30) outpatient visits for either individual or group therapy (or a combination of both) during each Benefit Period;

c) pursuant to the terms and conditions of the following Riders if they are in force with the Member's Certificate:

1) Mental Health Inpatient and Partial Hospitalization Services;
2) Non-Serious Inpatient Mental Illness Services (Groups of 50); and/or
3) Serious Mental Illness Services (Groups of 50).

3.16.2 **Substance Abuse (Applicable to Members of Groups with fifty (50) or less employees).** All Substance Abuse Covered Services must be obtained from a provider who participates in the Plan's Designated Behavioral Health Benefit Program. The following Substance Abuse services are covered:

3.16.2.1 **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 that participates in the Plan's Designated Behavioral Health Benefit Program 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 Participating 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™.

3.16.2.2 **Inpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse, when provided on an inpatient basis in a hospital which participates in the Plan's Designated Behavioral Health Benefit Program, or in an inpatient non-hospital facility which participates in the Plan's Designated Behavioral Health Benefit Program, is covered. 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.

3.16.2.2.1 **Cost Sharing**. Each admission or covered day of a hospital stay and related physician services, while receiving inpatient Detoxification services from a hospital which participates in the Plan's Designated Behavioral Health Benefit Program, are subject to the inpatient hospital Copayment amounts specified on the Schedule of Benefits. Inpatient hospital Cost Sharing shall be limited to the maximum dollar amount per hospital admission set forth on the Schedule of Benefits.

3.16.2.2.2 **Benefit Limit and Lifetime Benefit Maximum Admissions)**. Hospital inpatient Detoxification services for Substance Abuse are limited to a total of seven (7) days per admission and four (4) admissions per a Member's lifetime.

3.16.3 **Short Term Acute Outpatient Opioid Detoxification Treatment**. Short Term acute outpatient opioid detoxification treatment is covered when provided by a Provider who participates in the Plan's Designated Behavioral Health Benefit Program.

3.16.3.1 **Definition of Short Term**. For the purpose of Sections 3.16.3, 3.16.3.1 and 3.16.3.2, Short Term shall mean an uninterrupted four (4) month period of opioid detoxification treatment.

3.16.3.2 **Lifetime Benefit Maximum**. Short Term acute outpatient opioid detoxification treatment is limited to one (1) Short Term opioid detoxification treatment of four (4) months per a Member's lifetime.

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

3.16.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered when provided in a facility which participates in the Plan's Designated Behavioral Health Benefit Program. 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. Non-hospital residential inpatient rehabilitation services for Substance Abuse shall be limited to:

a) a Benefit Limit of thirty (30) days per Benefit Period; and
b) a total Lifetime Benefit Maximum of ninety (90) days per a Member's lifetime.

3.16.4.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered when provided by a facility which participates in the Plan's Designated Behavioral Health Benefit Program. 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. Outpatient rehabilitation services for Substance Abuse shall be limited to:

a) a Benefit Limit of thirty (30) outpatient, full-session visits or equivalent partial visits each Benefit Period; and

b) a Lifetime Benefit Maximum total of one hundred-twenty (120) outpatient full-session visits or equivalent partial visits per a Member's lifetime.

3.16.4.3 **Partial Hospitalization.** In addition to the annual benefits set forth above, the following partial hospitalization services are covered: (i) up to an additional thirty (30) separate sessions of outpatient or partial hospitalization days for rehabilitation services for Substance Abuse rehabilitation each Benefit Period; or (ii) the exchange of these additional outpatient partial hospitalization sessions on a two-for-one basis, for up to fifteen (15) additional days of non-hospital residential inpatient rehabilitation for Substance Abuse.

3.16.4.4 **Cost Sharing for Initial and Subsequent Courses of Treatment.** The following are the Cost Sharing amounts for the initial and subsequent courses of treatment**.**

i) **Initial Course of Treatment.** The initial course of treatment shall be considered to be the full range of Detoxification, treatment and supportive services carried out specifically to alleviate the dysfunction of the Member as set forth above in Sections 3.16.2, 3.16.3, 3.16.4.1, 3.16.4.2 and 3.16.4.3. The initial course of treatment shall be subject to the Cost Sharing amounts set forth on the Schedule of Benefits as well as Benefit Limits and Lifetime Benefit Maximum amounts as set forth in Sections 3.16.2.2, 3.16.3.2, 3.16.4.1 and 3.16.4.2 (expressed as admissions, days and visits).

ii) **Subsequent Course of Treatment.** Each subsequent course of treatment for a Member shall be subject to the Cost Sharing amounts as set forth on the Schedule of Benefits, as well as Benefit Limits and Lifetime Benefit Maximum amounts as set forth in Sections 3.16.2.2, 3.16.4.1, 3.16.4.2 and 3.16.4.3 (expressed as admissions, days and visits).

3.17 Mental Health and Substance Abuse Services.

NOTE: *To determine if this Section 3.17 applies to you, please refer to the bottom of your Schedule of Benefits where you will be directed to the applicable Mental Health and Substance Abuse Services section of this Certificate.*

3.17.1 **Mental Health Services (Applicable to Members of Groups of fifty-one (51) or more Employees).** All professional mental health Covered Services must be obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional who participates in the Plan's Designated Behavioral Health Program. A Member may access mental health Covered Services in the following manner:

a) as a hospital inpatient as set forth in Section 3.21.2 (b) of this Certificate;

b) as an outpatient;

c) pursuant to the terms and conditions of the following Riders if they are in force with the Member's Certificate:

1) Non-Serious Inpatient Mental Illness Services (Mental Health Parity - Groups of 51 or More);
2) Serious Mental Illness Services (Mental Health Parity - Groups of 51 or More); and/or
3) Autism Spectrum Disorder Services.

3.17.2 **Substance Abuse (Applicable to Members of Groups with fifty (51) or more employees).** The following Substance Abuse services are covered:

3.17.2.1 **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 that participates in the Plan's Designated Behavioral Health Program 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™.

3.17.2.2 **Inpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse, is covered when provided on an inpatient basis in a hospital which participates in the Plan's Designated Behavioral Health Benefit Program, or in an inpatient non-hospital facility which participates in the Plan's Designated Behavioral Health Benefit Program. 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.

3.17.2.2.1 **Cost Sharing.** Each admission or covered day of a hospital stay and related physician services, while receiving inpatient Detoxification services from a hospital which participates in the Plan's Designated Behavioral Health Benefit Program, are subject to the inpatient hospital Copayment amounts specified on the Schedule of Benefits. Inpatient hospital Cost Sharing shall be limited to the maximum dollar amount per hospital admission set forth on the Schedule of Benefits.

3.17.3 **Short Term Acute Outpatient Opioid Detoxification Treatment**. Short Term acute outpatient opioid detoxification treatment is covered when provided by a Provider who participates in the Plan's Designated Behavioral Health Benefit Program.

3.17.3.1 **Definition of Short Term**. For the purpose of Sections 3.17.3, 3.17.3.1 and 3.17.3.2, Short Term shall mean an uninterrupted four (4) month period of opioid detoxification treatment.

3.17.3.2 **Lifetime Benefit Maximum**. Short Term acute outpatient opioid detoxification treatment is limited to one (1) Short Term opioid detoxification treatment of four (4) months per a Member's lifetime.

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

3.17.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered when provided in a facility which participates in the Plan's Designated Behavioral Health Benefit Program. 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.

3.17.4.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered when provided by a facility which participates in the Plan's Designated Behavioral Health Benefit Program. 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.

3.17.4.3 **Partial Hospitalization.** Upon Prior Authorization, partial hospitalization services are covered for Substance Abuse rehabilitation.

3.17.4.4 **Cost Sharing**. Non-hospital residential inpatient rehabilitation, outpatient rehabilitation and partial hospitalization Substance Abuse services received from a Designated Behavioral Health Benefit Program Provider, are subject to the Cost Sharing amounts specified on the Schedule of Benefits.

* *If the Member has a Point of Service Rider supplementing their Certificate, not withstanding any language to the contrary in the Point of Service Rider, a Member may receive Mental Health and Substance Abuse Services from a Provider who does not participate in the Designated Behavioral Health Benefit Program. The use of Provider who does not participate in the Plan's Designated Behavioral Benefit Program will be subject to Out of Network Cost Sharing and may result in significant out-of-pocket expense for the Member.*

3.18 Newborn Coverage. Newborn children are covered from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary hospital and physician services required by a newborn child of a Member when ordered or provided by Participating Providers for the treatment of medically diagnosed congenital defects and birth abnormalities (as also set forth in Section 3.25.1 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 Sections 6.2.3 or 9.6 of this Certificate (as applicable).

3.19 Oral Surgery. The following limited oral surgicalservices are covered:

3.19.1 **Non-dental treatment of the mouth** relating to medically diagnosed congenital defects, birth abnormalities, or excision of tumors.

3.19.2 **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).

3.19.3 **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.

3.19.4 **Hospital and Ambulatory Surgical Center Services and Related Professional Services** provided in connection with a covered or non-covered 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 Prior Authorization.

3.19.5 **Deep Sedation or General Anesthesia and Related Professional Services** provided in connection with an inpatient or outpatient dental or oral surgery procedure are covered only if such services 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.

Such deep sedation or general anesthesia and related professional services coverage requires Prior Authorization by the Plan.

3.20 Ostomy Supplies. The Plan will cover ostomy supplies 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) when provided by a Participating Provider.

3.21 Physician Services.

3.21.1 **Hospital and Ambulatory Surgical Center Physician Services.** The services listed in Section 3.12 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

a) **Hospital.** The services set forth in Section 3.12 are Covered Services when provided by physician Participating Providers (or other physicians in response to an emergency) 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 3.12 are Covered Services when provided in an Ambulatory Surgical Center setting by physician Participating Providers (or other physicians in response to an emergency) or under the orders of a physician.

3.21.2 **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 **NOT COVERED** except as may be explicitly provided under the terms of the following Riders:

i) Mental Health Inpatient and Partial Hospitalization Services;
ii) Non-Serious Inpatient Mental Illness Services (Groups of 50);
iii) Non-Serious Inpatient Mental Illness Services (Mental Health Parity – Groups of 51 or More);
iv) Serious Mental Illness Services (Groups of 50); and/or
v) Serious Mental Illness Services (Mental Health Parity – Groups of 51 or More).

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

a) Preventive, diagnostic and treatment services listed below under **Preventive Services** in this Certificate when obtained from a Participating Provider as set forth in Section 3.1.1 of 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 by a Participating Provider with a Referral from the Member's Primary Care Physician;

c) injectable drugs (including those injectable drugs listed in Section 3.26 of this Certificate) when determined by the physician to be an integral part of care rendered by the physician during a visit, limited to the amount of drug administered during the visit;

d) Medically Necessary Covered Services received from a Non-Participating Provider when the Member obtains Prior Authorization because the

Member's medical condition requires Covered Services that cannot be provided by a Participating Provider.

3.22 Preventive Services. The following preventive health care services are covered when obtained from a Participating Provider as set forth in Section 3.1.1 of this Certificate:

3.22.1 **Periodic health assessments** provided upon a schedule advisable by the Member's Primary Care Physician, obstetrical or gynecological Participating Health Care Provider (as applicable) including:

a) medical history;

b) physical examination, including 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, an annual gynecological examination, including a pelvic examination and a clinical breast exam, Chlamydia screening and screening Pap smear in accordance with the recommendations of the American College of Obstetrics and Gynecology;

d) annual mammogram for women forty (40) years of age and older or any mammogram based on the Member's Primary Care Physician's, obstetrical or gynecological Participating Health Care Provider's recommendation for women under forty (40) years of age*;

e) DEXA scan (X-ray imaging test which measures bone density for osteoporosis); and

f) cholesterol screening and lipid panel.

*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.

3.22.2 **Well-child care** from birth which includes:

a) pediatric well-child visits; and

b) newborn screening including one (1) hematocrit and one (1) hemoglobin screening for infants under twenty-four (24) months.

3.22.3 **Pediatric and Adult Immunizations** in accordance with accepted medical practices excluding immunizations necessary for international travel. Pediatric immunizations shall include coverage for those child immunizations, including the immunizing agents which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. For purposes of this subsection, child is either the Subscriber and under twenty-one (21) years of age, or the Subscriber's spouse and under twenty-one (21) years of age, or a Family Dependent as defined in Section 6.2 of this Certificate.

3.22.4 **Diabetes Care** which includes HbA1c, LDL-C and nephropathy screening tests.

3.22.5 **Colorectal Screening** which includes fecal occult blood testing, flexible sigmoidoscopy and colonoscopy procedures.

3.22.6 **Additional Preventive Care Services** as specified on the Schedule of Benefits.

3.22.7 **Benefit Limits**. Benefit Limits for preventive services are set forth on the Schedule of Benefits.

3.23 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period when the service is obtained from a Participating Provider.

3.24 Rehabilitative Services. Upon Prior Authorization, physical, occupational and speech therapy is covered for up to forty-five (45) dates of service per Benefit Period. This forty-five (45) day Benefit 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 day towards the forty-five (45) day limit. Rehabilitative services must be obtained from a Participating Provider, and prescribed or approved in advance by the Member's Primary Care Physician or Participating Provider upon Referral.

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

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

3.25.2 **Sickness**, **Accidental Injury or Incidental to Surgery.** Upon Prior Authorization, 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.

3.26 Select Injectable Drugs. Subject to the terms and conditions set forth in this Certificate, the following injectable drugs are a Covered Service when provided by a Participating Provider. Such injectable drugs are subject to the Cost Sharing set forth in Section 3.26.1 and on the Schedule of Benefits.

- Amevive™ (alefacept)
- Aldurazyme™ (laronidase)
- Aralast™ (purified human alpha$_1$-proteinase inhibitor)
- Aranesp™ (darbepoetin alfa)
- Arranon™ (nelarabine)
- Avastin™ (bevacizumab)
- Boniva™ IV (ibandronate sodium)
- Cerezyme™ (imiglucerase)
- Cimzia™ (certolizumab)
- Eligard™ (leuprolide)
- Epogen™ (epoetin alpha)
- Erbitux™ (cetuximab)
- Fabrazyme™ (agalsidase beta)
- Firmagon™ (degarelix)
- Flolan™ (epoprostenol)
- IVIG™ (intravenous immunoglobulin)
- Ixempra™ (ixabepilone)
- Kepivance™ (palifermin)
- Lucentis™ (ranibizumab)
- Lupron Depot™ (leuprolide acetate)

- Macugen™ (pegaptanib)
- Mozobil™ (pleriafor)
- N-Plate™ (romiplostim)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Prialt™ (ziconotide)
- Procrit™ (epoetin alpha)
- Prolastin™ (purified human alpha$_1$-proteinase inhibitor)
- Reclast™ (zoledronic acid)
- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Rituxan™ (rituximab)
- Simponi™ (golimumab)
- Soliris ™ (eculizumab)
- Supprellin LA™ (histrelin)
- Synagis™ (palivizumab)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Trelstar™ (triptorelin)
- Tysabri™ (natalizumab)
- Velcade™ (bortezomib)
- Viadur™ (leuprolide)
- Visudyne™ (verteporfin)
- Vivaglobin™ (sub q immune glbulin)
- Vivitrol™ (naltrexone injection)
- Xolair™ (omalizumab)
- Zemaira™ (purified human alpha$_1$-proteinase inhibitor)

3.26.1 **Cost Sharing.** The Select Injectable Drugs listed above will subject the Member to the Copayment set forth on the Schedule of Benefits. The total Copayment amounts paid by the Member shall not exceed $1,500 per Member per Benefit Period.

3.27 Skilled Nursing Facility Services. Upon Prior Authorization, Covered Services, including room and board on a skilled bed status, in a skilled nursing facility which is a Participating Provider, is covered for the first sixty (60) days of any Period of Confinement. A Period of Confinement shall be defined as the period of time from the date of admission in a skilled nursing facility to the date of discharge. With respect to a Period of Confinement, the date of admission is counted as one (1) day and the date of discharge is not counted. If a Member is discharged from a skilled nursing facility and then readmitted for the same or a related condition within six (6) months, the second admission shall be counted as a continuation of the prior Period of Confinement.

3.28 Surgery for Treatment of Morbid Obesity. The cost of surgical treatment of morbid obesity is covered based upon the Member meeting the specific medical criteria as determined by the Plan. The surgical coverage requires Prior Authorization by the Plan and must be provided in a facility Participating Provider that is designated as an approved Level 1 Bariatric Center of Excellence.

3.29 Transplant Services and Authorization Requirements.

3.29.1 **Covered Services.** Upon Prior Authorization, 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 Prior Authorization)
(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 for certain services that would not otherwise be provided for under this Certificate.

3.29.2 **Prior Authorization.** All transplant surgery and transplant-related services (with the exception of corneal transplants) require Prior Authorization by the Plan. 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 upon Referral by the Member's Primary Care Physician and performed through a Participating Provider.

3.29.3 **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.

3.29.4 **Additional Opinion Policy for Transplants.** If a Member receives written notification from the Plan 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 Plan 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 Plan to obtain adequate information to make a determination regarding the proposed transplant procedure.

3.29.5 **Organ Donation.** Covered Services required by a Member as an organ donor for transplantation into another Member are covered upon Prior Authorization. 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 Plan;
b) for the medical expense directly associated with the organ donation; and
c) to the extent not covered by any other program of insurance.

3.29.5.1 **Cost Sharing.** The Member's Cost Sharing applicable to the organ donation benefit includes any Copayment or Coinsurance associated with the services provided to the non-Member donor.

3.29.6 **Human Leukocyte Antigen (HLA) Typing.** The maximum amount the Plan will pay for HLA typing benefits provided hereunder on behalf of any one (1) Member per approved transplant is set forth on the Schedule of Benefits.

3.29.7 **Self-Administered Prescription Drugs.** Except as set forth in this Section 3.29.7, self-administered prescription drugs provided on an outpatient basis to Members are **NOT COVERED** except as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider if such a Rider is listed on the Schedule of Benefits as being in place with this Plan.

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

a) covered only if the Member receiving Transplant Covered Services has coverage under the terms of an Outpatient Prescription Drug Rider or a Supplemental Generic Outpatient Prescription Drug Rider;

b) covered only when the organ transplantation is approved by the Plan;

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

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

3.29.8 **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 Plan guidelines. For information on submitting receipts and the Plan's specific guidelines for travel, lodging and meal reimbursement, please contact the Customer Service Team at the telephone number on the back of the Member's Identification Card.

3.29.9 **Retransplantation Services**. Retransplantation surgery and retransplantation-related services require Prior Authorization by the Plan.

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

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

3.30.2 **Scheduled Services.** Medically Necessary non-emergency ambulance transportation is covered.

3.31 Urgent Care. Urgent Care services received through Participating Providers in the Service Area are covered. Urgent Care services obtained from a Non-Participating Provider outside of the Service Area are covered 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.

3.31.1 **Cost Sharing**. The Specialist Copayment shall apply in lieu of the emergency room Copayment when a Member receives Covered Services in a designated Urgent Care facility.

3.32 Urological Supplies. Urinary supplies are covered when the Plan 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.

3.33 Voluntary Family Planning Services. Voluntary family planning services are limited to:

a) professional services provided by a Member's Primary Care Physician or obstetrical or gynecological Participating Health Care Provider related to the prescribing and fitting of a contraceptive device covered by this Certificate, and

b) services for diagnosis of infertility (except infertility procedures which are specifically excluded under this Certificate in Sections 4.15 and 4.27).

3.34 Weight Management Program. The Plan offers a program for weight management that includes education and management on appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. This program is offered only through the Plan's designated vendors contracted for these services. 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 Plan's designated participating weight management program vendors.

SECTION 4. EXCLUSIONS

4. EXCLUSIONS. THE FOLLOWING ARE NOT COVERED by the Plan unless they are explicitly provided as a Supplemental Health Service under the terms of a Rider (all of which are listed on the 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 with the service.

4.1 Acupuncture. Acupuncture is **NOT COVERED**.

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

4.3 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 provided in Certificate Sections 3.16 and 3.17. If a Member has coverage under the Autism Spectrum Disorder Services Rider and requires services under such Rider, the terms and conditions of the Rider will determine the behavioral services available for the Member.

4.4 Biofeedback. Biofeedback is **NOT COVERED**.

4.5 Blood and 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 or female breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 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 Complications Resulting from a Non-Covered Procedure or Service. If a Member receives a procedure or service (including but not necessarily limited to Cosmetic Surgery) which is not a Covered Service under this Certificate and the Member has a physical or medical complication in conjunction with, or as a result of, the procedure or service, services related to such complications are **NOT COVERED.**

4.9 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 may be explicitly provided under the terms of the following Rider: Eyewear.

4.10 Cosmetic Surgery. Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiologic function (not psychological) as determined by the Plan, is **NOT COVERED.** This exclusion does not apply to Covered Services set forth in Sections 3.14, 3.25.1 and 3.25.2.

4.11 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 **NOT COVERED.**

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

4.13 Dentistry. The Plan 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 Plan will cover expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.19.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth) or as may be explicitly provided under the terms of the following Rider: Impacted Wisdom Teeth.

4.14 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate at Sections 3.3.3 and 3.29.7 or as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider or the Autism Spectrum Disorder Services Rider if such Riders are listed on the Schedule of Benefits as being in place with this Certificate.

4.15 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 an Outpatient Prescription Drug Rider with Contraceptive coverage if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.

4.16 Drug Maintenance Programs. Drug maintenance programs for the treatment of outpatient drug detoxification, dependency or addiction are **NOT COVERED**. This exclusion includes but is not necessarily limited to the outpatient use of the drugs Suboxone™ (buprenorphine/naloxone) and Subutex™ (buprenorphine) in an outpatient drug maintenance program unless there is an Outpatient Prescription Drug Rider listed on the Schedule of Benefits as being in place with this Certificate**.** If such a Rider is in place with this Certificate, Suboxone™ and Subutex™ may be administered according to the terms and conditions of the Rider and Certificate Sections 3.16.3 through and including 3.16.3.2, (as applicable) or 3.17.3 through and including 3.17.3.2, (as applicable).

4.17 Elective Abortions. Abortions are **NOT COVERED** except for those which are Medically Necessary for the life or physical health of the mother or to terminate pregnancy caused by rape or incest.

4.18 Experimental, Investigational or Unproven Services. Experimental, Investigational or Unproven Services are **NOT COVERED**.

4.19 Failure to Obtain Prior Authorization. Certain designated Covered Services for which Prior Authorization is required but not obtained by the Member prior to the provision of such services are **NOT COVERED**.

4.20 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**.

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

4.22 **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**.

4.23 **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 Referrals and/or Prior Authorizations must be obtained even when the Plan is the secondary carrier.

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

4.25 **Hypnosis.** Hypnosis is **NOT COVERED**.

4.26 **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**.

4.27 **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 Plan, 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 is **NOT COVERED**.

4.28 **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.**

4.29 **Insured Obligations.** Any amounts for a Covered Service which are greater than Plan's Benefit Limit (except with respect to costs associated with Emergency Services) or which exceed the Lifetime Benefit Maximum set forth on the Schedule of Benefits, or amounts for any Covered Service which are applied toward satisfaction of the Copayment or Coinsurance amounts, or which exceed the specific Benefit Limits set forth on the Schedule of Benefits are **NOT COVERED**.

4.30 **Manipulative Treatment Services.** Manipulative treatment services are services rendered for the treatment or diagnosis of neuromusculoskeletal disorders and are **NOT COVERED** except as may be explicitly provided under the terms of the following three Riders and listed on the current Schedule of Benefits:

a) Manipulative Treatment American Specialty Health Networks (ASH Networks);
b) Manipulative Treatment Services Enhanced Option American Specialty Health Networks (ASH Networks); and/or
c) Manipulative Treatment Services.

4.31 **Maternity care outside the Service Area.** Maternity care for normal term delivery outside the Service Area is **NOT COVERED.**

4.32 **Mental Health Inpatient Services.** Mental health inpatient services including services of a psychiatric hospital or psychiatric unit of an acute hospital are **NOT COVERED** except as may be explicitly provided under the terms of the following Riders:

a) Mental Health Inpatient and Partial Hospitalization Services;
b) Non-Serious Inpatient Mental Illness Services (Groups of 50);
c) Non-Serious Inpatient Mental Illness Services (Mental Health Parity – Groups of 51 or More);
d) Serious Mental Illness Services (Groups of 50); and/or
e) Serious Mental Illness Services (Mental Health Parity – Groups of 51 or More).

4.33 Mental Health Inpatient Professional Services. Mental health inpatient professional Services provided by a licensed psychiatrist or clinical psychologist are **NOT COVERED** except as set forth in Section 3.21.2 (b) or as may be explicitly provided under the terms of the following Riders:

a) Mental Health Inpatient and Partial Hospitalization;
b) Non-Serious Inpatient Mental Illness Services (Groups of 50);
c) Non-Serious Inpatient Mental Illness Services (Mental Health Parity- Groups of 51 or More);
d) Serious Mental Illness Services (Groups of 50); and/or
e) Serious Mental Illness Services (Mental Health Parity-Groups of 51 or More).

4.34 Mental Health Partial Hospitalization Services. Mental Health Partial Hospitalization Services provided through a partial hospitalization (psychiatric day-care) program are **NOT COVERED** except as may be explicitly provided under the terms of the following Riders:

a) Mental Health Inpatient and Partial Hospitalization;
b) Non-Serious Inpatient Mental Illness Services (Groups of 50);
c) Non-Serious Inpatient Mental Illness Services (Mental Health Parity – Groups of 51 or More);
d) Serious Mental Illness Services (Groups of 50);
e) Serious Mental Illness Services (Mental Health Parity-Groups of 51 or More); and/or
f) Autism Spectrum Disorder Services.

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

4.36 No Obligation To Pay. Any type of drug, service, supply or treatment for which, in the absence of coverage hereunder, the Member would have no obligation to pay, is **NOT COVERED**.

4.37 Non-Participating Provider Mental Health or Substance Abuse Services. Mental health/Substance Abuse services obtained from a Provider who does not participate in the Plan's Designated Behavioral Health Benefit Program are **NOT COVERED** except for Emergency Services as expressly set forth in Section 3.7 of this Certificate and as set forth in Section 3.17 if the Member has a Point of Service Rider supplementing their Certificate.

4.38 Non-Participating Providers. Covered Services or supplies ordered by or received from Non-Participating Providers are **NOT COVERED**. The only exceptions are in the case of:

a) Emergency Services, as provided in Section 3.7 of this Certificate;
b) Urgent Care received outside the Service Area, as provided in Section 3.31 of this Certificate;
c) Covered Services under this Certificate in accordance with the continuity of care provisions for new and existing Members as provided in Section 2.5 of this Certificate;

d) Covered Services which are not available through a Participating Provider and for which Prior Authorization has been obtained from the Plan; or

e) If the Member has a Point of Service Rider supplementing their Certificate.

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

4.40 Not Medically Necessary. Covered Services which are not considered Medically Necessary by the Plan are **NOT COVERED** unless set forth as a Covered Service under Section 3.22, **Preventive Services**.

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

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

4.43 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.

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

4.45 Prescription Drug 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 or any applicable Riders, is **NOT COVERED**.

4.46 Prescription Bandages and Wound Dressings. Prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in Section 3.20 of this Certificate.

4.47 Private Duty Nursing. Hourly nursing care on a private duty basis is **NOT COVERED**.

4.48 Refraction Examinations. Examinations to determine the refractive error of the eye are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider: Refractions.

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

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

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

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

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

4.54 Services Provided by a Member's Relative or Self. Services rendered by a person who is the spouse, child, parent, grandparent, aunt, uncle, niece, nephew, or sibling or persons who

ordinarily reside in the household of the Member of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.

4.55 Services Related to or Required by a Non-Covered Service. Any service related to or required by a non-Covered Service, including but not limited to anesthesia or diagnostic services, is **NOT COVERED**.

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

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

4.58 Unauthorized Services. All unauthorized services are **NOT COVERED**. This includes any Covered Service **NOT**:

a) provided by the Member's Primary Care Physician;

b) provided by the Member's obstetrical or gynecological Participating Health Care Provider (for services within their scope of practice);

c) authorized in advance by the Plan's Designated Behavioral Health Benefit Program;

d) performed upon Referral by the Member's Primary Care Physician or obstetrical or gynecological Participating Health Care Provider (for services within their scope of practice) for Covered Services available through a Participating Provider; or

e) performed upon Prior Authorization by the Plan for Covered Services which are not available through a Participating Provider.

Emergency Services provided inside or outside the Service Area do not require Prior Authorization. See Section 3.7 for the Emergency Services protocol.

4.59 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 as determined by the Plan.

4.60 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.34 of this Certificate.

4.61 The Following Durable Medical Equipment (DME), Orthotic Devices and Prosthetic Devices are NOT COVERED:

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

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

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

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

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

4.61.6 **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 3.3.2 of this Agreement, are **NOT COVERED**.

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

4.61.8 **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.**

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

4.61.10 **Experimental or Research Equipment** which, as determined by the Plan, 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 Plan in accordance with the terms and conditions set forth in Section 1.25 of this Certificate.

4.61.11 **Home Monitoring Equipment** is **NOT COVERED,** except for apnea monitors and pulse oximeters which are covered for Members age seventeen (17) and younger**.**

4.61.12 **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**.

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

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

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

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

4.61.17 **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.**

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

4.61.19 **Non-Standard Equipment or Devices.** Deluxe Equipment or devices of any sort, which has been otherwise determined by the Plan to be non-Standard is **NOT COVERED.**

4.61.20 **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 3.6.2 of this Certificate.

4.61.21 **Replacement of Component Parts or Modification** of a Standard 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 3.6.4.1 of this Certificate is **NOT COVERED**.

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

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

SECTION 5. COMPLAINT AND GRIEVANCE PROCEDURE

The Plan maintains Complaint and Grievance processes each involving two (2) levels of internal review. In addition, the Member has the opportunity to appeal the decision through an external review process as well as an Expedited Grievance Review Procedure

5. COMPLAINT AND GRIEVANCE PROCEDURE.

At any time during the Complaint or Grievance process, a Member may choose to designate in writing a representative to participate in the Complaint or Grievance process on the Member's behalf ("Member's Representative"). In this Section 5 of the Certificate, the definition of "Member" shall include a Member's Representative. The Member shall be responsible to notify the Plan ***in writing*** of such designation as the Plan has an authorization form available for the Member's use.

The Plan shall make a Plan employee available to assist the Member, at no charge, in the preparation of a Complaint or Grievance if the Member makes the request for assistance at any time during the Complaint or Grievance process. The Plan's employee who has been made available to the Member may not have participated in a prior decision made by the Plan regarding the Complaint or Grievance. A Member may call the Plan's toll-free telephone number located on the back of the Member's Identification Card, Monday through Friday between the hours of 8:00 a.m. to 6:00 p.m. to obtain information regarding the filing and status of a Complaint or Grievance. The Member has the right to provide the Plan with written comments, documents, records or other information regarding the Complaint or Grievance.

The Plan will fully and fairly consider all available information relevant to the Complaint or Grievance, including any material submitted by the Member to the Plan, when making a determination. In the event a Member disagrees with the Plan's classification of a Complaint or Grievance, the Member may contact the Department of Health or Department of Insurance for consideration and intervention with the Plan in order to be redirected to the appropriate internal Plan review process. The Complaint or Grievance will also be classified as either a "Pre-Service" appeal or "Post-Service" appeal. "Pre-Service" appeals are appeals regarding services that have not yet occurred. "Post-Service" appeals are appeals for services that have already been rendered. The Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted, if the Member is a member of an ERISA group.

The Plan may not cancel or terminate a Member's coverage for services provided under this Certificate on the basis that the Member has exercised rights under the Plan's Grievance and Complaint procedure by registering a Complaint or Grievance against the Plan.

5.1 Complaint Procedure.

5.1.1 **First Level Complaint Review Procedure.** A Member who has a Complaint about his coverage, Participating Providers, or the operations or management policies of the Plan should contact the Customer Service Team. A Customer Service Team representative will attempt to satisfy the Member's issue informally. If the Customer Service Team representative is unable to resolve the Member's concern to his satisfaction, the Member may file a written or oral Complaint that will be reviewed by the First Level Complaint Review Committee. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of an adverse benefit determination or the occurrence of the issue, which is the subject of the complaint. The Plan shall notify the Member of its receipt in writing including a detailed explanation of the Complaint process.

5.1.1.1 **First Level Complaint Review Committee.** The First Level Complaint Review Committee shall include one (1) or more employees of the Plan, or its designee, who did not previously participate in a prior decision to deny the Member's Complaint and shall not be a subordinate of the person(s) who made the adverse benefit determination. Upon request from the Member, the Plan shall provide the Member with access to the information available relating to the matter being complained of at no cost and shall permit the Member to provide additional verbal or written data or other material in support of the Complaint.

5.1.1.2 **Time Frame for Decision.** The First Level Complaint Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from the receipt of the First Level Complaint and within five (5) business days of the First Level Complaint Review Committee's decision.

5.1.1.3 **Member Notification of Decision.** Notification to the Member shall include the basis for the decision and the procedure to file a request for a voluntary Second Level Complaint Review of the decision of the First Level Complaint Review Committee including:

a) a statement of the issue reviewed by the First Level Complaint Review Committee;

b) the outcome of the first level review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) a list of the titles and qualifications of the individuals participating in the review;

g) notification that the Member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Complaint/appeal at no cost and instructions as to how to obtain the same;

h) an explanation of how to request a voluntary Second Level Complaint Review of the decision of the First Level Complaint Review Committee and notification that the Member has the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the voluntary Second Level Complaint Review; and

i) the time frames for requesting a Second Level Complaint Review, if any.

5.1.2 **Second Level Complaint Review Procedure.** A Member who is dissatisfied with the decision of the First Level Complaint Review Committee may request orally or in writing a voluntary Second Level Complaint Review. A written request should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 North Academy Avenue, Danville, PA 17822. An oral request may be made by telephoning the Plan's Customer Service Team Representative. The Plan shall notify the Member of its receipt in writing, upon receipt of such request.

5.1.2.1 **Member Satisfaction Review Committee**. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the Plan or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's Complaint including any material submitted by the Member to the Plan. The Plan shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.1.2.2 **Time Frame for Decision.** The Second Level Complaint Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from the receipt of the Second Level Complaint and within five (5) business days of the Member Satisfaction Review Committee's decision.

5.1.2.3 **Member Notification of Decision.** The written notice shall specify the reasons for the Member Satisfaction Review Committee's decision and shall include the specific reason and basis for the decision and the procedures to file an appeal to the Department of Health or the Department of Insurance including the address and telephone numbers of both agencies and shall include the following information:

a) a statement of the issue reviewed by the Member Satisfaction Review Committee;

b) the outcome of the second level review;

c) the specific reasons for the decision in easily understandable language;

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol, or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion and notification that the Member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) a list of titles and qualifications of individuals participating in the review;

g) notification that the Member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Complaint/appeal at no cost and instructions as to how to obtain the same;

h) an explanation of how to request an External Complaint Appeal Review of the decision of the Member Satisfaction Review Committee by the Department of Health or the Department of Insurance, including the addresses and telephone numbers of both agencies, a description of the External Complaint Appeal process including notification that the Member has the right to provide additional material for inclusion in the External Complaint Appeal Review and a statement that the Member does not bear any costs for the External Complaint Appeal Review; and

i) the time frame for requesting an External Complaint Appeal Review, if any.

5.1.3 **External Complaint Appeal Review.** If the Member is not satisfied, the Member may appeal the decision of the Member Satisfaction Review Committee within fifteen (15) calendar days from receipt of the notice of the Second Level Complaint Review decision to the Pennsylvania Department of Health:

Bureau of Managed Care
Pennsylvania Department of Health
Health & Welfare Building, Room 912
7th & Forster Streets
Harrisburg, PA 17120
Telephone Number: (717) 787-5193 or 1-(888) 466-2787
AT & T Relay Service: 1-(800) 654-5984 (TT)
Fax Number: (717) 705-0947

OR the Pennsylvania Department of Insurance:

Pennsylvania Department of Insurance
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Telephone Number: (717) 787-2317 or 1-(877)-881-6388
Fax Number: (717) 787-8585

The Plan shall transmit to the appropriate Department all records from the First and Second Level Complaint Review processes within thirty (30) calendar days of the Department's request. The Plan and the Member may submit to the appropriate Department additional materials related to the Complaint. Each party shall provide to the other copies of the additional documents provided to the Department. The Plan and the Member have the right to be represented by an attorney or other individual before the appropriate Department. The appropriate Department shall have the final determination.

5.1.4 **Complaint Regarding Increase to Premium Rates.** A Member who has an inquiry, Complaint or question regarding the Plan's increase to premium rates may contact the Pennsylvania Department of Insurance without the necessity of following the Plan's First and Second Level Complaint Review Procedures.

5.2 Grievance Procedure-Medical Necessity and Appropriateness of Care Determinations.

5.2.1 **First Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, may file a **written** request (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) to have the Plan review the denial of payment for a health care

service based on Medical Necessity and appropriateness of care, including approval by the Plan of an alternative Covered Service or approval of a Covered Service for a lesser scope or duration than requested. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of an adverse benefit determination and should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 North Academy Avenue, Danville, PA 17822. The Plan shall notify the Member and Health Care Provider who filed the Grievance with the Member's written consent, of its receipt in writing including a detailed explanation of the Grievance process.

5.2.1.1 **First Level Internal Review Committee**. The First Level Internal Review Committee shall include one (1) or more individuals selected by the Plan. The committee consists of a Plan Medical Director (licensed physician) who did not previously participate in any prior decision relating to the Grievance and shall not be subordinates of the person(s) who made the adverse benefit determination. The First Level Internal Review Committee shall include written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the Member or a Health Care Provider with the Member's written consent, the Plan shall provide the Member or the Health Care Provider who filed the Grievance with the Member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material in support of the Grievance.

5.2.1.2 **Time Frame for Decision.** The First Level Grievance Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from receipt of the First Level Grievance and within five (5) business days of the Committee's decision.

5.2.1.3 **Member Notification of Decision**. Written notification to the Member and the filing Health Care Provider shall include the following:

a) a statement of the issue reviewed by the First Level Internal Review Committee;

b) the outcome of the First Level Grievance Review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (Subscription Certificate, Amendment, Rider) provision on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member or filing Health Care Provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Member's medical circumstances;

g) a list of the titles and qualifications of the individuals participating in the review;

h) notification that the Member or filing Health Care Provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Grievance/appeal at no cost and instructions as to how to obtain the same;

i) an explanation of how to request a voluntary Second Level Grievance Review of the decision of the First Level Internal Review Committee and notification that the Member or filing Health Care Provider have the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the voluntary Second Level Grievance Review; and

j) the time frames for requesting a Second Level Grievance Review, if any.

5.2.2 **Second Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the First Level Internal Review Committee may request in **writing** (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) a voluntary Second Level Grievance Review. Upon receipt, the Plan shall notify the Member and Health Care Provider who filed the Grievance of its receipt in writing.

5.2.2.1 **Second Level Internal Review Committee**. The Second Level Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination or of the First Level Internal Review Committee reviewers. The Second Level Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the Member or a Health Care Provider with the Member's written consent, the Plan shall provide the Member or the Health Care Provider who filed the Grievance with the Member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the Grievance. The Member and the Health Care Provider who filed a Grievance have the right to appear before the Second Level Internal Review Committee. The Plan and the Member have the right to be represented by an attorney or other individual before the Second Level Internal Review Committee. The Plan shall provide at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Second Level Grievance Review meeting to the Member and the Health Care Provider who filed the Grievance with the Member's written consent.

5.2.2.2 **Time Frame for Decision.** The Second Level Grievance Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered

with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from receipt of the Second Level Grievance and within five (5) business days of the Committee's decision.

5.2.2.3 **Member Notification of Decision**. Written notification to the Member and the filing Health Care Provider shall include the following:

a) a statement of the issue reviewed by the Second Level Internal Review Committee;

b) the outcome of the Second Level Grievance Review;

c) the specific reason(s) for the decision in easily understandable language;

d) a reference to the specific Plan contract (i.e. Subscription Certificate, Amendment, Rider) provisions on which the decision is based;

e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the Member or filing Health Care Provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same;

f) an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Member's medical circumstances;

g) a list of the titles and qualifications of the individuals participating in the review;

h) notification that the Member or filing Health Care Provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the Member's Grievance/appeal at no cost and instructions as to how to obtain the same;

i) an explanation of how to request an External Grievance Appeal Review by an independent Certified Review Entity (CRE) assigned by the Department of Health and notification that the Member or filing Health Care Provider has the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the External Grievance Appeal Review, including a statement that the Member and Member Representative do not bear any costs of the independent External Grievance Appeal Review; and

j) the time frame of fifteen (15) days from receipt of the written notification of the decision of the Second Level Grievance Review for the Member or the filing Health Care Provider to file a request for an External Grievance Appeal Review.

5.2.3 **External Grievance Appeal Review.** The Member or the Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the Second Level Internal Review Committee, may appeal to the Department of Health by filing a request, **in writing**, to the Plan **within fifteen (15) calendar days** of receipt of the notice of denial.

5.2.3.1 **Procedure.** The Plan shall contact the Member or the Health Care Provider who filed the External Grievance Appeal and the Department of Health within five (5) business days of the filing of the External Grievance Appeal. The Department will assign a CRE within two (2) business days of receiving the request. Within fifteen (15) calendar days of the receipt of the request for an External Grievance Appeal, the Plan shall forward copies of all written documentation regarding the Member's Grievance to the CRE assigned to perform the External Grievance Appeal. The Plan shall notify the Member and the filing Health Care Provider of the list of documents being forwarded to the CRE for the external review within fifteen (15) calendar days of receipt of the request. The Member or the filing Health Care Provider may supply additional information to the CRE, with copies to the Plan, for consideration in the External Grievance Appeal Review within fifteen (15) calendar days of filing the request with the Plan.

5.2.3.2 **Time Frame for Decision**. The External Grievance Appeal Review shall be completed and a decision rendered within sixty (60) calendar days of the request and a written response shall be provided to the Member and the filing Health Care Provider, the Plan and the Department. Notification to the Member and filing Health Care Provider shall include the basis for the decision and information that the Member or the filing Health Care Provider will have sixty (60) calendar days from receipt of the decision of the External Grievance Appeal Review to appeal to a court of competent jurisdiction.

5.3 Expedited Grievance Review Procedure. Should the Member's life, health or ability to regain maximum function be in jeopardy by delay caused by the Plan's review procedure, the Member or a Health Care Provider with the Member's written consent, may request an Expedited Grievance Review (orally or in writing). The Plan will perform an Expedited Grievance/Urgent Care Appeal Review when:

1) upon review by the Plan, the Member's request meets medical criteria to initiate the Expedited Grievance Review process; or
2) it is the Health Care Provider's opinion that the Member is subject to severe pain that cannot be managed without the care or treatment being requested; or
3) the Member provides the Plan with a certification, in writing, from the Member's physician stating that the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Pre-Service Grievance Process of thirty (30) days. The certification must include a clinical rationale and facts to support the physician's opinion; or
4) requests concerning admissions, continued stay or other health care service for a Member who has received emergency services but has not been discharged from a facility.

The Plan shall accept the above, perform an Expedited Grievance Review and render a decision within forty-eight (48) hours of receipt of the Member's request for an Expedited Grievance Review. The Member shall be responsible to provide information to the Plan in an expedited manner to allow the Plan to conform to the Expedited Grievance Review requirements.

The Expedited Internal Review Committee shall be comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the adverse benefit determination. The Expedited Grievance Review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health

care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review.

5.4 Expedited External Grievance Review Procedure. The Member or the Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the Plan's Expedited Grievance Review may appeal to the Department of Health by filing a request orally or in writing to the Plan within two (2) business days of receipt of the Expedited Grievance Review decision. The Plan shall submit to the Department of Health the Member's request for an Expedited External Grievance Review within twenty-four (24) hours of receipt. The Department, within one (1) business day of receiving the request for an Expedited External Grievance Review, will assign a CRE. The Plan shall be responsible to transfer documents regarding the review to the CRE for receipt on the next business day. The CRE shall have two (2) business days to review and render a decision. The assigned CRE is required to review and issue a written decision to the Member and the Member's Representative, the Health Care Provider, if the Health Care Provider filed the Expedited External Grievance with the Member's consent, the Plan and the Department of Health, within two (2) business days. The Expedited External Grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the Expedited External Grievance Review decision.

SECTION 6. ELIGIBILITY

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

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

a) a full-time resident of the Service Area or work within the Service Area and live within twenty (20) minutes or twenty (20) miles of a Participating Primary Care Physician; and

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

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

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

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

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

a) the spouse of a Subscriber; or

b) an unmarried dependent child whose age is less than the Maximum Age for dependent children as stated on the Schedule of Benefits.

6.2.1 A dependent child is defined as:

a) a natural child,

b) an adopted child or child placed for adoption,

c) a natural child or an adopted child of the Subscriber or the Subscriber's spouse, for whom the Subscriber is obligated to provide health care coverage through a court order, or qualified medical support order, or

d) any other child of whom the Subscriber or the Subscriber's spouse is the custodial parent, Legal Guardian or Legal Custodian. The Plan may periodically require documentary proof of such dependency.

A Family Dependent must reside in the Service Area or reside with the eligible Subscriber, unless the Family Dependent is covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania.

Eligibility shall cease for a dependent child on the last day of the month in which the dependent child reaches the Maximum Age, becomes married or obtains full-time employment (except for disabled dependent children and students). Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage.

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

6.2.3 **Newborn Child.** A newborn child of a Member is automatically covered under this Certificate for thirty-one (31) days from the date of birth. To continue coverage of a newborn, a request for addition to Family Coverage (or a change from single to Family Coverage) must be submitted to the Plan within thirty-one (31) days of the date of birth and all premium requirements shall be paid. No evidence of insurability shall be required.

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

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

6.2.5 **Children Born To Family Dependents.** A child born to a Family Dependent is automatically covered under this Certificate for thirty-one (31) days from the date of birth. To continue coverage of such child, the Subscriber must submit a request for addition to Family Coverage to the Plan within thirty-one (31) days of the date of birth and pay the required premium.

6.2.6 **Continued Coverage of Disabled Dependent Child.** An unmarried dependent child who exceeds the Maximum Age for dependent children and is:

a) incapable of self-sustaining employment by reason of disability resulting from mental retardation or a physical disability which meets the criteria under §88. 41 of Title 31, PA Code and who became so prior to the attainment of age nineteen (19); and

b) is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance,

may continue enrollment or will become eligible for enrollment under Family Coverage for the duration of such disability and dependency.

In addition, such unmarried dependent child must have been enrolled as a Family Dependent under this Certificate prior to reaching the age of nineteen (19) or under the terms of another Group health benefit program offered by the Group as an alternative to this Plan. The Plan may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the Plan is first notified of such disability and dependency, whichever is earlier.

6.2.7 **Students.** The Schedule of Benefits gives two (2) Maximum Ages for dependent children: one (1) for dependent children who are full-time students and one (1) for all other dependent children. The full-time student Maximum Age shall apply to an individual who is either a high school student or enrolled in an approved institution of higher learning pursing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study. The Plan may periodically require documentary proof of enrollment as a student upon reaching the Maximum Age for dependent children set forth on the Schedule of Benefits, or upon the date on which the Plan is first notified of such enrollment.

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

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

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

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

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

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

6.2.7.2 **Continuing Coverage of Full-Time Students on Medical Leave.** Federally enacted Michelle's Law extends coverage to dependent full-time students over the age of eighteen (18) who are enrolled in an institution of higher

education and who would otherwise lose health care coverage if a Medically Necessary leave of absence causes them to fall below full-time student status. To continue the student's coverage, the Plan must be provided with a physician's written certification of the student's serious illness or accident citing the Medical Necessity of the leave. Such coverage will be provided by the Plan for: a) up to one year after the first day of the leave of absence or b) the date the student's coverage would otherwise terminate under the terms and conditions of the Certificate; which ever date comes earlier. Under Michelle's Law regulations, the student will receive the same coverage as the Subscriber and other Family Dependents under the Certificate.

6.2.8 **Noncustodial Children.** A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order. The Subscriber must make written application for membership of such child. The Plan will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty (30) days of receipt by the Plan of said official court order. The Subscriber shall notify the Plan of the name and address of the custodial parent in order to allow the Plan to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania. The Plan may not disenroll or eliminate coverage of any child unless the Plan is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

6.3 Continued Eligibility During Military Service. If a Subscriber is called to Active Military Duty (for the purpose of this Section only, Active Military Duty is defined as voluntary or involuntary duty in a uniformed service under competent authority), coverage will continue under the Plan for the first thirty (30) days of the Active Military Duty. After the expiration of the first thirty (30) days, the Subscriber will be given the option of continuing health care coverage at their own expense through a COBRA or Mini-COBRA offering, as applicable, for themselves and their eligible Family Dependents. This offering will be at the same rate paid by the employer for the Subscriber's and the Subscriber's eligible Family Dependents' coverage. The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.22 of this Certificate.

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

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

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

b) have properly elected to receive COBRA coverage.

If a Member ceases to be eligible for enrollment under this Certificate as a result of a qualifying event, as defined under COBRA, and such Member has properly elected to receive COBRA coverage as set forth in COBRA, then such Member may continue coverage through the Group for up to the maximum period of time set forth under COBRA. Upon timely notice from the Group, the Plan will make continuation coverage available. The Group retains full responsibility for providing to Members all required notices and information relating to COBRA continuation coverage rights, as required by law. The Plan shall have no

obligation to notify Members of continuation coverage rights under COBRA. The Plan is not the COBRA administrator. The Member should contact the Group for specific information on how to elect COBRA coverage and the associated costs of such coverage. Premiums for COBRA coverage will be remitted to the Plan by:

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

ii) the Subscriber on behalf of himself and/or any Family Dependent(s).

6.4.1 **Post-COBRA Conversion Coverage**. A Subscriber and/or eligible Family Dependents shall be entitled to obtain a conversion policy upon termination of COBRA coverage according to the terms and conditions set forth in Section 9.3.11 of this Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

6.5.2 **Post Mini-COBRA Conversion Coverage.** A Subscriber and eligible dependents shall be entitled to obtain a conversion policy upon termination of Mini-COBRA coverage according to the terms and conditions set forth in Section 9.3.11 of this Certificate.

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

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

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

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

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

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

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

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

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

6.6 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the Plan by submitting a completed Enrollment Application on forms provided by the Plan (or provided by the Group if approved by the Plan). No eligible person will be refused enrollment within thirty-one (31) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a special enrollment period. No evidence of insurability shall be required.

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

6.7.1 **Special Enrollment Period-Loss of Eligibility Status.** An individual who loses eligibility for enrollment under another group health benefits program may enroll in this Plan at a time other than an Open Enrollment Period, if the Plan receives satisfactory evidence that:

a) the individual was actually enrolled for benefits under the other program at the time he first became eligible for this Plan;

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

c) the individual was enrolled in the other program during the most recent Open Enrollment Period, if eligible for this Plan at that time;

d) loss of eligibility under the other program was as a result of:

i) termination of employment;
ii) reduction in the number of hours of employment;
iii) termination of the other program's coverage;
iv) termination of contributions toward the premium made by the Group;
v) death of a spouse, divorce, or legal separation;
vi) expiration of the COBRA or Mini-COBRA continuation of coverage period (for COBRA or Mini-COBRA eligible Groups);
vii) no longer working or residing in the service area when the other program (such as an HMO) does not provide benefits to an individual who no longer works or resides in the service area; or
viii) meeting or exceeding a lifetime limit on all benefits under the other program; **AND**

e) application for enrollment in this Plan is made within thirty-one (31) days of the last date of eligibility under the other program.

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

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

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

For employer Groups, a Pre-Existing Condition exclusion may apply as follows:

6.8 Pre-Existing Condition Exclusion. Coverage for Pre-Existing Conditions shall begin after the Member has been covered under this Plan for twelve (12) months. This exclusion applies to all services, with the exception of those set forth in this Certificate. The Pre-Existing Condition exclusion shall begin from the date of enrollment under the Certificate and credit shall be given for the time the Member had Creditable Coverage as set forth in Section 6.8.2. To the extent that this Certificate replaces another group contract, the Plan shall only apply a pre-existing condition exclusion if excluded by the other group policy.

6.8.1 **Exceptions to Pre-Existing Condition Exclusion.** The Pre-Existing Condition Exclusion set forth in this Section is not applicable to:

a) a newborn child;

b) an adopted child or a child pending placement (under 18 years of age);

c) a newborn child born to a Family Dependent;

d) a new spouse;

e) services provided by the Member's Primary Care Physician;

f) Emergency Services;

g) pregnancy;

h) genetic information (in the absence of diagnosed condition); or

i) to Members for whom this Certificate replaces prior group coverage that did not contain the pre-existing condition exclusion.

6.8.2 **Creditable Coverage.** The Pre-Existing Condition Exclusion period may be reduced in the event a Member has had insurance coverage through another health insurer. The Member may have received a certificate with information regarding prior Creditable Coverage from the Member's previous employer, insurer or other health benefits provider. The certificate of Creditable Coverage is extremely useful for demonstrating Creditable Coverage. If the Member does not have such a certificate, the Member has the right to request one (within twenty-four (24) months after coverage ceases). At the Member's request, the Plan will assist the Member in obtaining the certificate of Creditable Coverage. The Member can request assistance from the Plan by calling the Customer Service Team at the telephone number indicated on the back of the Member's Identification Card.

6.9 Hospitalization on the Effective Date. A Member who is hospitalized prior to the effective date of coverage hereunder is covered for Covered Services (s) as of the effective date of enrollment in the Plan unless:

a) they are covered under a continuation of benefits provision through another carrier; or

b) they are an admitted patient in a non Participating Provider facility who does not accept the Plan's terms and/or benefits.

Expenses incurred prior to the effective date of enrollment in the Plan are **NOT COVERED**.

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

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

7. PAYMENT PROVISIONS.

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

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

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

7.4 Grace Period. If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within thirty (30) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 9.3.1 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 9.6 of this Certificate. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependents during the grace period.

SECTION 8. LIMITATIONS

8. LIMITATIONS.

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

8.2 Coordination of Benefits.

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

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

i) group-type health benefits coverage, whether insured or uninsured, which is not available to the general public;

ii) coverage under a governmental health benefits program or a program required by law. This does not include a state program under Medicaid (Title XIX, Grants to States for Medical Assistance programs of the United States Social Security Act, as amended from time to time). It also does not include any health benefits program that by law the benefits exceed those of any private insurance program or any other non-governmental program.

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

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

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

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

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

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

d) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one (1) or more Programs covering the Member for whom the claim is made.

The term Allowable Expense does not include coverage for items **NOT COVERED** under this Certificate. When This Plan provides Covered Services, the reasonable cash value of each service is the Allowable Expense and is considered a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the Member's stay in a private hospital room is Medically Necessary.

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

8.2.2 **Applicability.**

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

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

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

8.2.3 **Order of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In such event, the benefits of This Plan will be reduced so that they and the benefits payable under the other Programs do not total more than the Allowable Expenses. When the benefits of This Plan are reduced as described herein, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

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

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

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

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

b) insurance companies; or

c) other organizations.

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

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

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

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

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

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

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

e) This Plan is **secondary** to Medicare when the Subscriber is under the age of sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability, is an Active Employee (defined by Medicare regulations) and works for an employer with less than one hundred (100) employees.

f) If the Subscriber has End Stage Renal Disease (ESRD) the Plan will be primary for the first thirty (30) months of the Subscriber's entitlement to Medicare (as defined by Medicare regulations). After the first thirty (30) months, Medicare will become the primary coverage. However, if the Plan is currently providing benefits as the secondary provider when the Subscriber becomes entitled to ESRD Medicare benefits, the Plan will remain the secondary provider. The same conditions apply as indicated above in regard to ESRD if the Subscriber has COBRA coverage under the Plan.

The Subscriber is strongly encouraged to refer to Medicare regulations in regard to the specific requirements for Medicare entitlement.

8.2.9.2 **Double Coverage.** The benefits provided under this Certificate are not designed to duplicate any benefits for which a Member may be eligible under the terms of Medicare, any government-sponsored health benefits program or any applicable Worker's Compensation Law. Benefits hereunder will be reduced to the extent that benefits are eligible for payment regardless of whether the Member has enrolled for participation under Medicare or any government-sponsored health benefits program. Benefits also will be reduced to the extent that benefits are received by the Member under any form of Worker's Compensation coverage. In the event a Member fails to receive benefits for which he is otherwise eligible under the terms of Medicare, any government-sponsored health benefits program or Worker's Compensation because of the failure of the Member to apply for or maintain Medicare or any government-sponsored health benefits program coverage, or to submit required claim documentation or other required documentation, benefits under this Certificate will be reduced by the amount of benefits which the Member would otherwise have received under Medicare, any government-sponsored health benefits program or Worker's Compensation. **If the Member enters into an agreement to settle the Worker's Compensation claim, any future expenses for Covered Services rendered for the injury compensated by the settlement are NOT COVERED.**

8.3 Subrogation. The Plan has the right of subrogation to the extent permitted by the law against third parties that are legally liable for the expenses paid by the Plan under this Certificate. The Member shall do nothing to prejudice the subrogation rights of the Plan. The Plan may recover benefits amounts paid under this Certificate under the right of subrogation to the extent permitted by law.

SECTION 9. TERM AND TERMINATION

9. TERM AND TERMINATION.

9.1 Term. The effective date of this Certificate is stated on the Schedule of Benefits. The initial term of this Certificate commences on such effective date and continues until the renewal date of the Group Master Policy. This Certificate shall automatically be renewed thereafter from year-to-year, unless sooner terminated as set forth below.

9.2 Termination by the Group. The Group may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Group shall result in the individual rights to benefits and Covered Services awarded under this Certificate ceasing on the effective date of termination, except as set forth in Section 9.6 Continuation of Benefits.

9.3 Termination by the Plan. The Plan may terminate this Certificate for the following reasons:

9.3.1 **Failure to Pay.**

9.3.1.1 **By the Subscriber.** In the event any Subscriber fails to pay any amount due the Plan, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the Plan to the Group and to the Subscriber. A Member whose coverage is terminated under this Section for failure to pay may not reapply for a period of eighteen (18) months following such termination.

9.3.1.2 **By the Group.** In the event the Group fails to pay any amount due the Plan, for the benefit of the Subscriber or any Family Dependents, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the Plan to the Group and to the Subscriber. A Member whose coverage is terminated due to the Group's failure to pay pursuant to this Section and who continues to reside in the Service Area may be eligible for conversion to individual, direct payment coverage without evidence of insurability, provided that application is made within thirty-one (31) days of the date of notification of termination and subject to payment of premiums as billed within thirty-one (31) days of the date such bill is issued. If the Member fails to apply with the Plan for conversion coverage within thirty-one (31) days of the date of the termination notification date, the Member upon future application to the Plan will need to provide evidence of insurability as part of the process.

9.3.2 **Fraud or Material Misrepresentation.**

9.3.2.1 **By the Group.** In the event the Group makes an intentional misrepresentation for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.2.2 **By the Member.** If it is proven that the Member attempted or committed fraud under this Certificate to obtain benefits or payment or if the Member makes an intentional misrepresentation of material fact in the application

for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber and the Group. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

A Member whose coverage is terminated under this Section for fraud or material misrepresentation may not apply to the Plan for health coverage for a period of thirty six (36) months following such termination.

9.3.3 **Violation of the material terms of the contract.**

9.3.4 **Failure to Continue to Meet the Group Eligibility Requirements.** If a Member ceases to meet the Group eligibility requirements, coverage shall terminate subject to fifteen (15) days written notice by the Plan to the Group and the Subscriber.

9.3.5 **Termination of Group Master Policy.** The Plan may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Plan means that individual rights to benefits and Covered Services awarded under this Certificate cease on the effective date of termination. If a Member whose coverage was terminated pursuant to this Section has succeeding or alternate carrier health service coverage, they are not eligible for conversion to individual, direct payment coverage. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 9.6 of this Certificate.

9.3.6 **Failure to Establish Physician-Patient Relationship.** If a Primary Care Physician is unable to establish or maintain a satisfactory physician-patient relationship with a Member, coverage of the Member (including all enrolled Family Dependents if the Member in question is the Subscriber) may be terminated, subject to the following: (i) the Plan has in good faith provided the Member with an opportunity to select another Primary Care Physician; (ii) the Member has repeatedly refused to follow the plan of treatment ordered by a Primary Care Physician or other physician providing services under the terms of this Certificate; and (iii) the Member is notified in writing at least thirty (30) days in advance that the Plan considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination subject to the Plan's Complaint procedure. Such termination shall be subject to thirty-one (31) days written notice by the Plan to the Group and the Subscriber and the decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.7 **Residence Out of the Service Area.** To be eligible to enroll, and to continue enrollment in the Plan, a Member must be a full-time resident of the Service Area, or reside with a Subscriber who works within the Service Area and lives within twenty (20) miles or twenty (20) minutes of a Participating Primary Care Physician. Except for students or a Family Dependent covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania, any Member who:

a) is absent from the Service Area for more than ninety (90) consecutive days; or

b) works within the Service Area but no longer lives within twenty (20) miles or twenty (20) minutes of a Participating Primary Care Physician

shall no longer be considered a permanent resident of the Service Area and coverage shall be terminated upon fifteen (15) days written notice by the Plan to the Group and the Subscriber.

9.3.8 **Subscriber's Death.** In the event of the death of a Subscriber, coverage shall terminate for his enrolled Family Dependents on the last day of the period for which payments have been made by, or on behalf of such Subscriber, subject to the conversion privilege set forth below. Surviving Family Dependents may also be eligible to continue Group coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 9.6.

9.3.9 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage with respect to the child subject to fifteen (15) days written notice by the Plan to the Group and the Subscriber. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.10 **Disruptive Behavior.** The Plan may terminate a Member's coverage for cause if the Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his continuing membership in the Plan seriously impairs the Plan's ability to provide Covered Services to either that Member or to other Members. Termination will occur after the Plan has made a reasonable effort to resolve the problem presented by the Member, including encouraging the Member to utilize Plan's internal Complaint procedure as set forth in Section 5 of this Certificate.

9.3.11 **Conversion Privileges.** If a Member's coverage terminates for any reason other than non-payment of a required contribution and the Member has been continuously insured under the Certificate for at least three (3) months immediately prior to termination, the Member shall be eligible for individual conversion coverage (referred to as "Conversion Coverage").

A Member is not entitled to Conversion Coverage if other similar group coverage will replace this Certificate within thirty-one (31) days, or if coverage terminated under the Certificate because the Member failed to pay required premium contributions. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA or Mini-COBRA eligible Groups) are eligible for conversion coverage when their COBRA or Mini-COBRA eligibility for Group coverage expires.

The Plan will give the Member written notice of the conversion privilege within fifteen (15) days before or after the date of termination of coverage. The Member must apply for Conversion Coverage and pay the applicable premiums within thirty-one (31) days after the termination of coverage under the Certificate, or within fifteen (15) days after the Plan provides the Member notice of conversion rights, whichever is later.

The Member may enroll in Conversion Coverage without a medical examination. The first premium payment must be received before Conversion Coverage will be put in force. Conversion Coverage shall begin the day after termination of coverage under the Certificate.

9.4 Reinstatement.

9.4.1 The Plan shall automatically reinstate a Member whose coverage has been terminated due to a clerical error on behalf of the Plan, when the Plan becomes aware of any clerical error. Automatic reinstatement by the Plan under this Section will not

require reapplication or submission of evidence of insurability. Premiums shall be payable from the effective date of reinstatement.

9.4.2 At the Plan's sole discretion, the Plan may reinstate a Member whose coverage has been terminated:

a) for loss of eligibility, if the Member recaptures eligibility status and continues to satisfy the eligibility requirements; or

b) at the Subscriber's request, if the Subscriber or the Group notifies the Plan within thirty-one (31) days of the date of the initial request to terminate that termination is no longer desired.

9.5 Refunds. When a Member's coverage is terminated, any periodic payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded or credited to the Group. Neither the Plan nor Participating Providers shall have any further liability under this Certificate.

9.6 Continuation of Benefits. If a Member is an inpatient in a hospital or skilled nursing facility on the effective date of termination, the benefits for inpatient Covered Services shall be provided:

1. until the inpatient stay ends; or
2. until any applicable Benefit Limit has been reached; or
3. until the Member becomes covered without limitation as to the condition for which he or she is receiving inpatient care under any other group coverage; or
4. up to the end of the Benefit Period;

whichever occurs first.

In the event coverage terminates because of active employment termination, the Covered Services will be provided for twelve (12) months during total disability with respect to the sickness or injury which caused the disability unless coverage is afforded for total disability under another group plan.

9.7 Health Status. Members enrolled under this Certificate will not have coverage terminated because of health status or requirements for health services.

SECTION 10. GENERAL PROVISIONS

10. GENERAL PROVISIONS.

10.1 Disclaimer of Liability. It is expressly understood that the Plan (as a corporation or otherwise) does not furnish any health service benefits. The Plan contracts with professional providers of care for the Covered Services received by Members under this Certificate. The Plan's obligation is limited to furnishing Covered Services through contracts with such providers of care. The Plan (as a corporation or otherwise) is not, in any event, liable for any act or omission of the professional personnel of any medical group, hospital, or other provider of services.

10.2 Designation of an Authorized Representative. Members have the right to designate an authorized representative who, in addition to the Member receiving services, will receive Explanation of Benefits forms from the Plan. If a Member wishes to designate an authorized representative, they must complete and sign an authorized representative form. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member Identification Card.

10.3 Claims and Reimbursement.

10.3.1 **Claims.** The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to a Member as follows:

a.) **Participating Provider Claims.** The timely filing of claims is the responsibility of the Participating Provider, and the Member will have no payment responsibility for such claim which is not filed on a timely basis by the Participating Provider.

b.) **Non-Participating Provider Claims.** Members are required to file a claim for all services rendered by a Non-Participating Provider. No payment will be made for any claims filed by a Member for services rendered by a Non-Participating Provider unless the Member gives written notice of such claim to the Plan within one (1) year of the date of service.

To file a claim, the Member should call the Plan at the telephone number listed on the Member Identification Card to obtain a claim form. Section A of the claim form must be signed by the Member before the Plan will issue payment to a provider or reimburse the Member for services received under this Certificate. The Member must complete a claim form for services rendered by a Non-Participating Provider and submit it, together with an itemized bill, to the following address:

Geisinger Health Plan
P.O. Box 8200
Danville, PA 17821-8200

If a claim form is not received by the Member within fifteen (15) days of request to the Plan, the Member may provide an itemized bill from the provider containing the following information, in writing, in lieu of the claim form:

1.) Full name of Member for whom the services were rendered.

2.) Date(s) of service.

3.) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
   a. Procedure/Service codes (and Modifiers)
   b. Diagnosis codes
   c. Location code

4.) Charges for each service.

5.) Servicing provider/facility and address. If available, telephone number and provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Health Plan
P.O. Box 8200
Danville, PA 17821-8200

Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof of loss is otherwise required.

10.3.2 **Reimbursement.** In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, the Plan will reimburse the Member by check immediately upon receipt of the written proof of claim set forth under Section 10.3.1 of this Certificate. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the Plan as soon as possible, but in no event later than one year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

10.4 Amendments. The provisions of this Certificate cannot be altered or changed by any representative or agent of the Plan, other than by a written Amendment or Rider signed by the President or other authorized officer of the Plan.

10.5 Authorization to Disclose Confidential Information. Subject to the Medical Records confidentiality provisions, the Plan is entitled to receive from any provider of Covered Services to any Member, information reasonably necessary in connection with the administration of this Certificate.

10.6 Modifications. Through the Group Master Policy, the Group makes coverage under this Certificate available to persons who are eligible. However, the Group Master Policy and this Certificate shall be subject to amendment, modification or termination in accordance with any provision thereof or hereof without the consent or concurrence of or notice to the Members, except as provided for herein. By electing coverage pursuant to this Certificate or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, amendments and provisions thereof and hereof. Disclosure of information regarding a change to benefits shall be provided to Members within thirty (30) days of the effective date of the change.

10.7 Enrollment Applications and Statements. Members or applicants for membership shall complete and submit to the Plan such Enrollment Applications, or other forms or statements as the Plan may reasonably request. Members and applicants for membership represent that all information contained in such Enrollment Applications, forms or statements submitted to the Plan prior to enrollment under this Certificate or the administration hereof shall be true, correct and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct and complete.

10.8 Policies and Procedures. The Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Certificate.

10.9 Computation of Time. Unless otherwise specifically stated, all references in this Certificate to "day" shall mean calendar day. All references to "effective date" shall mean 12:01 a.m. of such calendar date determined on the basis of the location of the Plan's address.

10.10 Clerical Error. Clerical error, whether of the Group or the Plan, in keeping any record pertaining to the coverage under this Certificate will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10.11 Gender. All pronouns used herein shall include both the masculine and the feminine gender, as the context requires.

10.12 Notices. Any notice under this Certificate may be given by United States Mail, first class, postage prepaid, addressed as follows:

Geisinger Health Plan
M.C. 3220
100 North Academy Avenue
Danville, PA 17822
Attention: Administration

Claims and requests for reimbursement should be sent to the attention of the "Claims Department." Notice to a Member will be sent to the Member's last address known to the Plan.

10.13 Substitution of Non-Covered Services. Other provisions of this Certificate notwithstanding, the Plan reserves the right to provide any service, supply, equipment or benefit which is otherwise **NOT COVERED**, or which is limited or excluded, when, in the sole judgment of the Plan, provision of such service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equivalent benefits available under this Certificate. Any such substitution shall be subject to such quality assurance standards as the Pennsylvania Department of Health may establish.

10.14 Certificate of Creditable Coverage. Upon termination of a Member's coverage, the Plan will automatically issue a Certificate of Creditable Coverage. The Certificate of Creditable Coverage indicates the length of time the Member had continuous health coverage under the Plan. In the event additional Certificates of Creditable Coverage are required, the Member has the right to request them within twenty-four (24) months after coverage terminates or at any time while enrolled in the Plan. A Member may request a Certificate of Creditable Coverage by contacting the Customer Service Team at the telephone number on the back of the Member's Identification Card.

10.15 Discretionary Authority. The Plan has the full discretionary authority to make benefit and eligibility determinations and adjudicate claims under the Group's health benefit plan.

10.16 Compliance with the Law; Amendment. Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Certificate, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Certificate for any one (1) or more eligible Members enrolled under this Plan, and each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose, provided that the changes described in such Amendment are made on a uniform basis consistent with the provisions of HIPAA.

10.17 Governing Law. This Certificate is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Certificate shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

EXHIBIT 1
GEISINGER HEALTH PLAN
SERVICE AREA

SERVICE AREA shall mean the following counties located in Pennsylvania: Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Elk, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York.

(In Bedford and Elk Counties, only areas within the listed U.S. Postal Service zip codes identified below are included):

BEDFORD COUNTY
- the following zip codes only:
15521
15554
16614
16633
16650
16655
16659
16664
16667
16670
16672
16678
16679
16695

ELK COUNTY
- the following zip codes only:
15821
15822
15823
15827
15831
15841
15846
15860
15868

GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Impacted Wisdom Teeth

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force. Services must be received from a Participating Provider.

1. **BENEFIT.**

   1.1 Subject to the Limitations below the Plan will pay 100% of the cost of services, including consultation, for the extraction of partially or totally bony impacted third molars when performed by a Participating Provider.

2. **LIMITATIONS.**

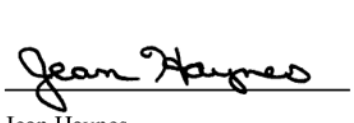
   2.1 **Hospital and Ambulatory Surgical Center Services**. Hospital and Ambulatory Surgical Center services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, are covered only if the hospital services are required for an existing medical condition unrelated to the dental or oral surgical procedure. Such coverage must be authorized in advance by the Plan.

3. **EXCLUSIONS.** The following are **NOT COVERED** under this Rider.

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

   3.2 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.

   3.3 Impacted Wisdom Teeth services that are not obtained from a Participating Provider are **NOT COVERED.**



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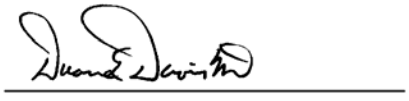

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Non-Serious Inpatient Mental Illness Services
(Mental Health Parity - Groups of 51 or More)

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force. Services must be obtained from Participating Providers in the Plan's Designated Behavioral Health Benefit Program.

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

1.1 **Non-Serious Mental Illness** means any mental illness 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.

2. BENEFITS.

2.1 **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 that participates in the Plan's Designated Behavioral Health Benefit Program, (including the cost of services provided by a psychiatrist, licensed clinical psychologist or other licensed behavioral health professional who participates in the Plan's Designated Behavioral Health Benefit Program), is covered.

2.2 **Professional Services.** Professional services of psychiatrists, licensed clinical psychologists or other licensed behavioral health professionals who participate in the Plan's Designated Behavioral Health Benefit Program are covered when provided in conjunction with covered Non-Serious Mental Illness inpatient or partial hospitalization services.

3. COST SHARING.

3.1 Mental health inpatient services are subject to the applicable Cost Sharing amounts as set forth on the Schedule of Benefits.

4. EXCLUSIONS.

4.1 **Non-Serious Mental Illness Services**. Non-Serious Mental Illness services obtained from Providers who do not participate in the Plan's Designated Behavioral Health Program are **NOT COVERED.***

** If the Member has a Point of Service Rider supplementing their Certificate, not withstanding any language to the contrary in the Point of Service Rider, a Member may receive Non-Serious Inpatient Mental Illness Services from a Provider who does not participate in the Designated Behavioral Health Benefit Program. The use of a Provider who does not participate in the Plan's Designated Behavioral*

Benefit Program will be subject to Out of Network Cost Sharing and may result in significant out-of-pocket expense for the Member.

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Outpatient Prescription Drugs - With Contraceptives
Three Tier Prescription Benefit

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force. Outpatient Prescription Drugs may be prescribed by either a Participating or non-Participating Provider, but must be obtained from a Participating Pharmacy or Participating Mail Order Pharmacy.

1. **DEFINITIONS.** For the purpose of this Rider, the following definitions shall apply:

1.1 **Brand Name Drug** as used in this Rider 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.

1.2 **Drug Formulary or Formulary** means a continually updated list of prescription medications that represents the current covered drugs by the Plan based upon the clinical judgment of the Plan'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 and this Rider. Subsequent updates to the Formulary may be obtained by contacting the Plan at the phone number on the back of the Member's Identification Card or can be viewed on the Plan's Web site at www.thehealthplan.com.

1.3 **Formulary Brand Name Drug** means a Brand Name Drug which is included in the Plan's Drug Formulary.

1.4 **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 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 Plan's sole discretion, such as the First Data Bank; and (iv) approved by the Plan.

1.5 **Mail Order Prescription Drug** means any Maintenance Prescription filled through the Plan's Mail Order Prescription Drug Program.

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

1.7 **Non-Formulary Brand Name Drug** as used in this Rider, means a Brand Name Drug not listed in the Plan's Drug Formulary.

1.8 **Participating Mail Order Pharmacy** means a pharmacy that has in effect on the date of service, an agreement with the Plan to provide Mail Order Prescription Drugs to Members under the provisions of this Rider, and is so designated by the Plan.

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1.9 **Participating Pharmacy** means a pharmacy which has in effect on the date of service, an agreement with the Plan to provide Prescription Drugs to Members under the provisions of this Rider, and is so designated by the Plan. For pharmacies that are not in the Plan's Service Area, Prescription Drugs or refills may be filled at pharmacies contracted through the Plan's pharmacy claims processor.

1.10 **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 and which is prescribed for use as an outpatient. 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 Plan. Prescription Drug does not include those drugs expressly excluded under Section 5 of this Rider.

2. **PRESCRIPTION DRUG TIERS.** Prescription Drug Tiers are subject to the Copayment or Coinsurance amounts as set forth on the Schedule of Benefits. Drugs in each tier may require Prior Authorization in order for the drugs to be Covered Services. Please refer to Section 4.2 of this rider.

1st Tier – This includes most Generic Drugs. Prior Authorization is generally not necessary for drugs in this tier.

2nd Tier – This includes certain Generic Drugs as well as Formulary Brand Name Drugs with no Generic Drug equivalent. Prior Authorization may be necessary for coverage of certain drugs in this tier.

3rd Tier – This includes certain Formulary Brand Name Drugs with a Generic Drug equivalent and Non-Formulary Brand Name Drugs. It may also include certain Generic Drugs on occasion. Prior Authorization may be necessary for coverage of certain drugs in this tier.

3. **BENEFIT.**

3.1 Subject to the Cost Sharing amounts as set forth on the Schedule of Benefits, and the limitations as set forth herein, Formulary Prescription Drugs prescribed for a Member as a result of Covered Services provided and covered under the terms of the Certificate to which this Rider is annexed, are covered when provided by a Participating Pharmacy and/or Participating Mail Order Pharmacy, as applicable.

3.2 Subject to the Cost Sharing amounts as set forth on the Schedule of Benefits, and the Limitations as set forth herein, restricted drugs and certain drugs requiring Prior Authorization prescribed for a Member as a result of Covered Services provided and covered under the terms of the Certificate to which this Rider is annexed, are covered only upon Prior Authorization by the Plan and provided by a Participating Pharmacy and/or Participating Mail Order Pharmacy, as applicable.

3.3 Human growth hormone covered under this Rider is subject to the Coinsurance amount as set forth on the Schedule of Benefits.

3.4 The following over-the-counter medications are covered when an oral or written prescription for the item is provided by a Participating Health Care Provider and the item is obtained from a Participating Pharmacy or a Participating 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; and

d. **low dose aspirin** (at 81.0 mg strength only) is covered for Members ages 45 through 70.

4. **LIMITATIONS.**

4.1 **Quantity.** Notwithstanding the limitation set forth in Section 4.1.1 specific to Mail Order Prescription Drugs, the maximum quantity of any drug covered under this Rider, per prescription 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 Plan's discretion. Additional quantity restrictions may apply in accordance with the Formulary or within this Rider.

4.1.1 **Mail Order Prescription Drugs – Quantity.** The quantity of any Mail Order Prescription Drug covered under this Rider, per prescription or refill, is a quantity required to last for a period of 90 days. Additional quantity restrictions may apply in accordance with the Formulary or within this Rider.

4.2 **Drugs Requiring Prior Authorization.** Some drugs require Prior Authorization by the Plan in order for the drugs to be Covered Services. These drugs are identified in the Drug Formulary. Requests for Prior Authorization must be directed to the Plan's Pharmacy Services Team.

4.3 **Non-Formulary Drugs.** Certain Prescription Drugs may not be included on the Drug Formulary. Prior Authorization by the Plan is required for drugs not included on the Drug Formulary.

4.4 **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 per Copayment or Coinsurance.

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

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

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

4.6 **Manufacturer.** The Plan reserves the right to restrict the manufacturer of Prescription Drugs covered under this Rider. Such restriction is subject to change by the Plan without the consent or concurrence of the Members, except as provided for herein.

4.7 **Assignment of Drugs to Tiers.** The Plan 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.

4.8 **Cost Sharing and Benefit Limit.** Prescription Drugs covered under this Rider shall be subject to the applicable Cost Sharing, Benefits, and Limitations described in Sections 2, 3 and 4 of this Rider and as set forth on the Schedule of Benefits.

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

5. **EXCLUSIONS.** The following are **NOT COVERED** under this Rider:

5.1 Drugs which are not Prescription Drugs, as defined herein.

5.2 **Devices.** The following non-contraceptive and contraceptive devices are not covered under this Rider:

5.2.1 **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 the Certificate at Section 3.3.1, **Diabetic Medical Equipment**), diagnostic devices and supplies.

5.2.2 **Contraceptive Devices.** Prescription or non-prescription contraceptive devices (except diaphragms which are covered under this Rider), including but not limited to condoms and implantable devices for the purpose of releasing contraceptive drugs.

5.3 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.

5.4 Smoking cessation aids, including but not limited to nicotine replacement drugs (except Chantix™ and Generic Zyban™ (buproban) as described in Section 4.5 of this Rider).

5.5 Prescription Drugs prescribed for weight loss or weight management.

5.6 Over-the-counter drugs and other items available without a prescription, whether provided with or without a prescription, including but not limited to aspirin, oxygen, cosmetics, medicated soaps, food supplements, vitamins, bandages and spermicidal agents (except those over-the-counter medications listed in Section 3.4 of this Rider).

5.7 Restricted drugs or drugs requiring Prior Authorization by the Plan which have not received such authorization in advance. The Plan reserves the right to require Prior Authorization for selected drugs (listed in the Drug Formulary) before providing coverage for such drugs.

5.8 Non-Formulary Drugs, restricted drugs or drugs requiring Prior Authorization by the Plan which have been obtained prior to receiving such authorization.

5.9 Prescription Drugs not accepted as standard medical treatment of the condition being treated as determined by the Plan, or any such drug requiring Federal or other governmental agency approval not granted at the time the drug was dispensed.

5.10 Prescription Drugs prescribed for cosmetic indications, 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).

5.11 Dietary supplements, vitamins (except prescription prenatal), fluoride supplements/rinses, (except for those over-the-counter medications listed in Section 3.4 of this Rider), anabolic steroids, blood plasma products or irrigation solutions.

5.12 Insulin and oral pharmacological agents for controlling blood sugar; disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips) which are covered as a Covered Service under Sections 3.3.1 and 3.3.3 of the Certificate as part of **Diabetic Medical Equipment, Supplies, Prescription Drugs and Services**.

5.13 Drugs that are not Medically Necessary as determined by the Plan.

5.14 Medications for erectile dysfunction.

5.15 Replacement for lost, destroyed or stolen prescriptions.

5.16 Immunizations, except those which are covered as Covered Services under Exhibit 2 of the Certificate as Preventive Services.

5.17 Allergy injections.

5.18 Extemporaneous dosage forms of natural estrogen or progesterone, including but not limited to oral capsules, suppositories and troches.

5.19 Prescriptions dispensed in unit doses, when bulk packaging is available.

5.20 Prescription Drugs which are not included on the Drug Formulary unless authorized in advance by the Plan.

5.21 Drugs written as Prescription Drugs which are available without a prescription in the same strength.

5.22 Prescription Drugs obtained from Non-Participating Pharmacies or Non-Participating Mail Order Pharmacies are **NOT COVERED**.

5.23 The Prescription Drugs Suboxone™ and Subutex ™ or any Generic equivalent of these drugs are **NOT COVERED** unless they are prescribed for use in an uninterrupted short term acute outpatient Opioid Detoxification treatment program of four (4) continuous months (limited to one (1) uninterrupted period of four (4) months per a Member's lifetime) as specifically set forth in Section 3 of the Certificate.

5.24 Prescription bandages and other wound dressing products.

5.25 Use of a Prescription Drug by anyone other than the Member listed on the prescription.

5.26 Medications that are repackaged by the supplier and sent to the pharmacy for fulfillment of prescriptions.

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES
FOR
CITIGROUP, INC.

Refractions

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Schedule of Benefits of which it is currently listed as being in force. Services must be received from Participating Providers.

1. **BENEFIT.**

   1.1 Subject to the Limitations set forth in this Rider, the Plan will pay 100% of the cost of an examination to determine the refractive error of the eye.

2. **LIMITATIONS.**

   2.1 **Benefit Limit.** Refraction services as provided under this Rider to any Member shall be limited to one (1) examination per twenty-four (24) months. Members must pay for any refraction services received above this maximum.

   2.2 Services must be performed by a Participating Provider who is: (i) a Doctor of Optometry; or (ii) a Medical Doctor who specializes in Ophthalmology.

3. **EXCLUSIONS**. The following are **NOT COVERED** under this Rider.

   3.1 Optical materials (eyeglasses, contact lenses) or their fitting, repair or replacement.

   3.2 Additional ophthalmological services provided during the same visit as the refractive exam, unless such services are performed upon Referral from the Member's Primary Care Physician and provided for in the Certificate.

   3.3 Refraction services that are not obtained from Participating Providers are **NOT COVERED.**

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Serious Mental Illness Services
(Mental Health Parity – Groups of 51 or More)

THIS RIDER provides **MANDATED BENEFITS** under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force. Services must be obtained from Participating Providers in the Plan's Designated Behavioral Health Program.

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

1.1 **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.

1.2 **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.

2. BENEFITS.

2.1 The Mandated Benefits described in this Rider are provided to groups of fifty-one (51) or more employees.

2.2 **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 that is a facility which participates in Plan's Designated Behavioral Health Program, (including the cost of services provided by a psychiatrist, licensed clinical psychologist, or other licensed behavioral health professional who participates in the Plan's Designated Behavioral Health Program), is covered

2.3 **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 who participate in the Plan's Designated Behavioral Health Program, is covered

3. COST SHARING.

3.1 Mental health inpatient, partial hospitalization and outpatient professional services for the treatment of Serious Mental Illness are subject to the applicable Cost Sharing amounts as set forth on the Schedule of Benefits.

4. EXCLUSIONS.

4.1 **Serious Mental Illness Services.** Serious Mental Illness services obtained from Providers who do not participate in the Plan's Designated Behavioral Health Program are **NOT COVERED**.*

** If the Member has a Point of Service Rider supplementing their Certificate, not withstanding any language to the contrary in the Point of Service Rider, a Member may receive Serious Mental Illness Services from a Provider who does not participate in the Designated Behavioral Health Benefit Program. The use of a Provider who does not participate in the Plan's Designated Behavioral Benefit Program will be subject to Out of Network Cost Sharing and may result in significant out-of-pocket expense for the Member.*

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES
FOR
CITIGROUP, INC.

Autism Spectrum Disorder Services

THIS RIDER provides **MANDATED BENEFITS** under the terms of the Geisinger Health Plan Subscription Certificate ("Certificate") when this Rider is listed on the current Schedule of Benefits as being in force.

1. **DEFINITIONS**. For the purpose of this Rider, the following definitions shall apply:

1.1 **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.

1.2 **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.

1.3 **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.

1.4 **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.

1.5 **Participating Pharmacy** means a pharmacy which has in effect on the date of service, an agreement with the Plan to provide prescription drugs to Members and is so designated by the Plan. For pharmacies that are not in the Plan's Service Area, prescription drugs or refills may be filled at pharmacies contracted through Argus Health Systems, Inc.

1.6 **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.

1.7 **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 Plan 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 Plan and the licensed physician or licensed psychologist developing the Treatment Plan.

2. **BENEFITS.**

2.1 The Mandated Benefits described in this Rider are provided to employer groups of fifty-one (51) or more employees.

2.2 **Autism Spectrum Disorder Services.** Coverage for Autism Spectrum Disorder Services is provided to Members under 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.

2.2.1 **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 Participating Pharmacy.

2.2.1.1 **Cost Sharing.** Pharmacy Care Services Cost Sharing shall be as follows:

a) For Members with an Outpatient Prescription Drug Rider, Pharmacy Care Cost Sharing shall be that indicated on the Schedule of Benefits for the Outpatient Prescription Drug Rider.

b) For Members without Outpatient Prescription Drug coverage, the Pharmacy Care Cost Sharing shall be 50% Coinsurance.

2.2.2 **Psychiatric Care Services.** Psychiatric Care Services include direct or consultative services provided by a physician Autism Spectrum Disorder Provider who specializes in psychiatry. Psychiatric Care Services must be provided by an Autism Spectrum Disorder Provider who participates in the Designated Behavioral Health Benefit Program.

2.2.2.1 **Cost Sharing.** Psychiatric Care Services Cost Sharing shall be subject to the Deductible, Coinsurance, and Coinsurance Maximum amounts as set forth on the Schedule of Benefits, listed under "Mental Health Services" as "Outpatient Professional Services" .

2.2.3 **Psychological Care Services.** Psychological Care Services include direct or consultative services provided by a psychologist Autism Spectrum Disorder Provider. Psychological Care Services must be provided by an Autism Spectrum Disorder Provider who participates in the Designated Behavioral Health Benefit Program.

2.2.3.1 **Cost Sharing.** Psychological Care Services Cost Sharing shall be subject to the Deductible, Coinsurance, and Coinsurance Maximum amounts as set forth on the Schedule of Benefits, listed under "Mental Health Services" as "Outpatient Professional Services".

2.2.4 **Rehabilitative Care Services.** Rehabilitative Care Services include professional Autism Spectrum Disorder Provider services and treatment programs, including Applied Behavioral Analysis, 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 who participates in the Designated Behavioral Health Benefit Program.

2.2.4.1 **Cost Sharing**. Rehabilitative Care Services Cost Sharing shall be subject to the Deductible, Coinsurance, and Coinsurance Maximum amounts as set forth on the Schedule of Benefits, listed under "Physician Office Services" as "Specialist Office Visit".

2.2.5 **Therapeutic Care Services.** Therapeutic Care Services require Prior Authorization by the Plan and include services provided by speech language pathologist, occupational therapist or physical therapist Autism Spectrum Disorder Providers. Therapeutic Care Services must be provided by a Participating Provider. If the Member has a Point of Service Rider supplementing their Certificate, not withstanding any language to the contrary in the Point of Service Rider, a Member may receive Therapeutic Care Services from a *Non-Participating Autism Spectrum Disorder Provider.

2.2.5.1 **Cost Sharing**. Therapeutic Care Services Cost Sharing for services received from a Participating Provider shall be subject to the Deductible, Coinsurance, and Coinsurance Maximum amounts as set forth on the Schedule of Benefits, listed under "Physician Office Services" as "Specialist Office Visit".

2.3 **Expedited Review**. Upon the Plan'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 Grievance Review Procedure set forth in Section 5.3 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.

2.4 **Subscription Certificate Amendment**. Exclusion 4.3, "Behavioral Services", of the Certificate is hereby amended to not include any behavioral services covered by this Rider as an Autism Spectrum Disorder service. Accordingly, Exclusion 4.14, "Drugs", is amended to not include any outpatient drugs used in the assessment or Treatment of Autism Spectrum Disorder services.

3. BENEFIT LIMIT.

3.1 **Benefit Limits Listed on the Schedule of Benefits**. Benefit Limits set forth on the Schedule of Benefits are not applicable to Autism Spectrum Disorder services covered by this Rider.

4. **EXCLUSIONS.**

4.1 Psychiatric Care Services, Psychological Care Services and Rehabilitative Care Services obtained from Providers who do not participate in the Plan's Designated Behavioral Health Program are **NOT COVERED.**

4.2 Pharmacy Care Services obtained from non–Participating Pharmacy Providers are **NOT COVERED.**

4.3 Therapeutic Care Services obtained from a Non-Participating Provider are **NOT COVERED** unless the Member has a Point of Service Rider supplementing their Certificate.

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GEISINGER HEALTH PLAN SOLUTIONS
RIDER FOR SUPPLEMENTAL HEALTH SERVICES
FOR
CITIGROUP, INC.

Manipulative Treatment Services

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force. Services must be obtained from Participating Providers.

1. **BENEFITS**.

1.1 **Manipulative Treatment Services**. Subject to the Cost Sharing as set forth on the Schedule of Benefits and the Benefit Limit set forth in this Rider, the Member may access certain Medically Necessary manipulative treatment services when prescribed in advance by the Member's Primary Care Physician, or a Participating Provider on Referral by a Primary Care Physician, or when approved in advance by the Plan. Manipulative treatment services must be provided by a Participating Provider qualified to perform these services.

Manipulative treatment services covered under this Rider are limited to:

- Manipulative Treatment
- Electrical Stimulation – Attended
- Ultrasound
- Exercise Therapy; Strength and Endurance; Range of Motion
- Re-Education Posture and Proprioception
- Exercise Therapy; Improve Functional Performance

2. **COST SHARING**.

2.1 **Cost Sharing**. Manipulative treatment services are subject to the Deductible, Coinsurance, and Coinsurance Maximum amounts as set forth on the Schedule of Benefits.

2.2 **Benefit Limit.** Manipulative treatment services provided under this Rider to any Member shall be limited to fifteen (15) visits each Benefit Period. Members must pay for any Manipulative treatment services received above this Benefit Limit.

3. **EXCLUSIONS.**

3.1 Manipulative treatment services that are not obtained from Participating Providers are **NOT COVERED.**

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GEISINGER HEALTH PLAN HMO
RIDER FOR SUPPLEMENTAL HEALTH SERVICES
FOR
CITIGROUP, INC.

Domestic Partner with Family Dependent(s)

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Group Subscription Certificate when this Rider is listed on the current Schedule of Benefits as being in force.

1. **DEFINITIONS.** For the purpose of this Rider, the following definitions shall apply:

   1.1 **Family Dependent** for purposes of this Rider only shall mean an unmarried or married natural child(ren) or adopted child(ren) of the Subscriber's Domestic Partner, or any other child(ren) of whom the Subscriber's Domestic Partner is the Legal Guardian or Legal Custodian whose age is less than the Maximum Age for dependent children as stated on the Schedule of Benefits and for whom the applicable premium for Family Coverage has been paid. The Plan may periodically require documentary proof of such dependency.

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

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

2. **BENEFITS.**

   2.1 A Subscriber who: (i) has demonstrated a Domestic Partnership; and (ii) has satisfied the eligibility requirements as set forth in this Rider and the Certificate, may arrange for Family Coverage by enrolling his or her Domestic Partner and Family Dependent(s) in the Plan at any time during an Open Enrollment Period.

   The effective date of coverage of the Domestic Partner and Family Dependent(s) under the Certificate to which this Rider is attached, will be predetermined by the Plan and the Group. Premiums for such coverage of a Domestic Partner and Family Dependent(s) shall be payable from the date which the Domestic Partner and Family Dependent(s) become enrolled in the Plan. No proof of insurability shall be required.

   2.2 Once enrolled, each Member must continue to meet the applicable eligibility criteria as set forth in this Rider and the Certificate to which this Rider is attached. Loss of eligibility, which includes termination of a Domestic Partnership, shall result in termination of coverage effective the day after the date upon which eligibility ceases.

   The Subscriber shall be responsible to notify the Plan and the Group in writing immediately upon termination of such Domestic Partnership.

3. CONTINUATION COVERAGE.

3.1 While not eligible for COBRA benefits under federal law, a Domestic Partner and Family Dependent(s) of a Subscriber's Domestic Partner shall be eligible to receive continuation coverage under the same terms as set forth in COBRA, subject to Section 6.4 of the Certificate.

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Group Benefit Changes Effective April 1, 2012, Upon Your Group's Renewal

Changes to the Subscription Certificate and Schedule of Benefits

- Diabetic eye examinations will now be covered with no cost sharing required.
- Pulmonary function tests will now be covered with no cost sharing required.
- Coverage for durable medical equipment will increase from $2,500 to $5,000 per benefit period.
- The following therapies are excluded from coverage: ayurveda, craniosacral therapy, guided imagery, hippotherapy, homeopathy, massage therapy, naturopathy, reiki, therapeutic touch and yoga
- Breast reductions for females are covered when medically necessary. Prior authorization is required for coverage; GHP's policy guidelines must be met. Breast reductions for males will continue to be excluded from coverage.
- The following drugs have been added to the list of covered injectable drugs for which cost-sharing applies. For a complete list, contact the customer service department. Cost sharing will increase from $75 to $100. Out-of-pocket maximum is $1,500.
    - Arzerra™
    - Berinert™
    - Eloxatin™
    - Halaven-T™
    - Kalbitor™
    - Lumizyme™
    - Prolia™
    - Xgeva™
    - Xiaflex™
    - Benlysta™
    - Yervoy™

Point-of-Service Rider (if applicable)
The following (A) services and/or supplies or (B) agents and/or medications require precertification as described in the Subscription Certificate, **Section 2B, SELF-REFERRED COVERED SERVICES**.
Please note those items with an asterisk (*) are not covered when provided by non-preferred providers.

A. Services and/or supplies:

1. Advanced Molecular Topographic Genotyping *
2. Autologous Chondrocyte Implantation
3. Bioengineered Skin Equivalents (including, but not limited to, Dermagraft ™ , Allograft and Apligraf ™ (Graftskin) – a type of skin graft)
4. Blepharoplasty (plastic surgery of the eyelids)
5. Breast Reduction/Reconstruction – unrelated to previous mastectomy for Breast Cancer
6. Cochlear Implants (surgically implanted hearing device)
7. Comparative Genomic Hybridization (CGH) for Evaluation of Developmental Delay
8. Deep Brain Stimulation
9. Durable Medical Equipment (DME)*
10. Dorsal Column Stimulation (spinal column stimulation)
11. Electrical Stimulation to aid bone healing; invasive procedure (surgical procedure related to bone growth stimulator)
12. Extracorporeal Shock Wave Treatment (ESWT) for Musculoskeletal Indications
13. Extraction of Teeth and Alveoloplasty (limited to extractions performed by an oral surgeon that are required prior to organ transplantation, cardiac or radiation procedures)
14. Fetal Surgery (surgery on the unborn child)
15. Gene Expression Profiling for Breast Cancer *
16. Genetic Testing for BRCA1 or BRCA2 for Breast or Ovarian Cancer
17. Genetic Testing Related to Colorectal Cancer
18. Health Care Services Associated with Non-Covered Services (such as anesthesia related services to noncovered dental extractions)
19. Home Health Services (including home infusion services)
20. Hospice
21. Injection Therapy for Back Pain*
22. Inpatient Facility Admission
23. Intensity Modulated Radiation Therapy (IMRT)
24. Mental Health and Substance Abuse Services:

    i.) Inpatient and Partial Hospitalization Services. For members of groups of 51 or more (refer to the bottom of your Schedule of Benefits to determine if you are in such a group of 51+), precertification is required when mental health and substance abuse inpatient and partial hospitalization services are obtained from a provider who does not participate in GHP's designated behavioral health benefit program.

    ii.) Outpatient Services. Precertification is required for the following outpatient services:

a. Intensive outpatient program treatment
b. Outpatient electro-convulsive treatment
c. Psychological testing
d. Outpatient treatment of Opioid dependence
e. Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
f. Outpatient treatment provided in the member's home
g. Biofeedback
h. Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder

25. Non-Emergency Outpatient Radiology (CT, Echocardiography, MRI, MRA, PET, Nuclear Cardiology, SPECT, Virtual Colonoscopy)
26. Obesity Surgery*
27. Orthognathic Surgery (including, but not limited to mandibular and maxillary osteotomies)
28. Osseointegrated Hearing Device (BAHA Hearing Device)
29. Outpatient Rehabilitation Services (occupational, physical or speech therapy)
30. Pectus Excavatum or Carinatum (surgical correction of chest deformity)
31. Proton Beam Radiation
32. Restorative or Reconstructive Surgical Procedures (except for a medically necessary mastectomy as set forth in Section 3.14 of the Subscription Certificate which is not subject to precertification)
33. Rhinoplasty as stand-alone procedure or Rhinoplasty with Major Septal Repair
34. Sacral Nerve Stimulation (treatment to improve bladder control)
35. Selective Internal Radiation Therapy
36. Septoplasty as stand-alone procedure/Septoplasty in conjunction with other planned medically necessary surgery
37. Skilled Nursing Facility Admission
38. Stereotactic Radiosurgery (including but not limited to Cyberknife, GammaKnife, LINAC, Neuromate, Nerhkoordinaten Manipulator (MKM))
39. Transmyocardial Laser Revascularization (TMLR) (when performed as a stand-alone procedure– process to increase blood supply to the heart)
40. Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells.* Inpatient hospitalization for transplant services **may not be self-referred**.
41. Vagal Nerve Stimulation (electrical stimulation for seizure control)
42. Varicose Vein Procedures (including injection of sclerosing solution into varicose leg veins and vein stripping)

B. Agents and/or Medications:

1. Abraxane™ (paclitaxel protein-bound particles)
2. Actemra™ (tocilizumab)
3. Aldurazyme™ (laronidase)
4. Amevive™ (alefacept)
5. Aralast*™ (human alpha$_1$-proteinase inhibitor)
6. Aranesp™ (darbepoetin alfa)

7. Arranon™ (nelarabine)
8. Arzerra™ (ofatumumab)
9. Avastin™ (bevacizumab)
10. Benlysta™ (belimumab)
11. Berinert™ (C1 esterase inhibitor)
12. Bexxar™ (tositumomab and iodine 131 tositumomab)
13. Botox™ (botulinum toxin A and B)
14. Cerezyme™ (imiglucerase)
15. Cimzia™ (certolizumab pegol)
16. Cinryze™ (C1 esterase inhibitor)
17. Clolar™ (clofarabine)
18. Cubicin™ (daptomycin)
19. Dacogen™ (decitabine)
20. Elaprase™ (idursulfase)
21. Elitek™ (rasburicase)
22. Eloxatin™ (oxaliplatin)
23. Epogen™ (epoetin alfa)
24. Eraxis™ (anidulafungin)
25. Erbitux™ (cetuximab)
26. Erythropoietin Stimulating Agents
27. Fabrazyme™ (agalsidase beta)
28. Faslodex™ (fulvestrant)
29. Flonan™ (epoprostenol)
30. Halaven – T™ (eribulin mesylate)
31. Hyalgan™(hyaluronate sodium)
32. Ilaris™ (canakinumab)
33. Intravenous (IV) Boniva (ibandronate sodium)
34. Intravenous Immune Globulin (IVIG)
35. Istodax™ (romidepsin)
36. Ixempra™ (ixabepilone)
37. Jevtana™ (cabazitaxel)
38. Kalbitor™ (ecallantide)
39. Leukine™ (sargramostim)
40. Lumizyme™ (alglucosidase alfa)
41. Myozyme™ (alglucosidase alfa)
42. Naglazyme™ (galsulfase)
43. Neulasta™ (pegfilgrastim)
44. Neupogen™ (filgrastim)
45. Nplate™ (romiplostim)
46. Nulojix™ (belatacept)
47. Ontak™ (denileukin diftitox)
48. Orencia™ (abatacept)
49. Orthovisc™ (hyaluronate sodium)
50. Prialt™ (ziconotide intrathecal infusion)
51. Procrit™ (epoetin alfa)
52. Prolastin™(human alpha$_1$-proteinase inhibitor)
53. Prolia™ (denosumab)
54. Provenge™ (sipuleucel-T)
55. Remicade™ (infliximab)
56. Remodulin™ (treprostinil)
57. Rituxan™ (rituximab)

58. Soliris™ (eculizumab)
59. Stelara™ (ustekinumab)
60. Supartz™(hyaluronate sodium)
61. Supprelin™ LA (histrelin acetate implant)
62. Synagis™ (palivizumab)
63. Torisel™ (temsirolimus)
64. Treanda™ (bendamustine)
65. Tysabri™ (natalizumab)
66. Vectibix™ (panitumumab)
67. Velcade™ (bortezomib)
68. Vfend™ (voriconazole)
69. Viscosupplementation
70. Vitrasert™ (ganciclovir intravitreal implant)
71. Vivitrol™ (naltrexone microspheres)
72. White Blood Cell Stimulating Factors
73. Xgeva™ (denosumab)
74. Xiaflex™ (collagenase clostridium histolyticum)
75. Xolair™ (omalizumab)
76. Yervoy™ (ipilimumab)
77. Zemaira™(human alpha$_1$-proteinase inhibitor)
78. Zevalin™ (ibritumobab tiuxetan)

This document summarizes benefit changes. The Subscription Certificate, Schedule of Benefits and riders are the governing documents.