Group Subscription Certificate

(This Subscription Certificate
also applies to Small Business)
(Rev. 4/07)

M-150-013-F Rev. 04/07

GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822-3020

HEALTH MAINTENANCE ORGANIZATION
Group Subscription Certificate

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.

The coverage provided to you is defined by the following documents:

1. The Group Subscription Certificate (the Certificate), which identifies Basic Health 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 Basic Health 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 Basic Health Services included in the Certificate;
4. The Face Sheet to the Certificate, which sets forth, among other things, Copayment, Deductible and Coinsurance amounts expected for Covered Services, the Benefit Period (as may be applicable);
5. Enrollment Application, which is the Subscriber's written request for enrollment; and
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.

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), Face Sheet and the Enrollment Application to enroll in the Plan constitute the entire agreement between the Subscriber named on the Face Sheet 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), Face Sheets, 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 our 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;

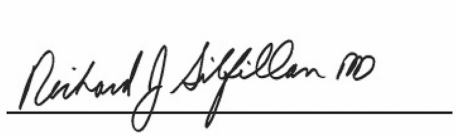
- a description of the process by which a Participating Health Care Provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in 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 1-800-447-4000 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 us at Geisinger Health Plan, Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3029.

Needs of non-English speaking enrollees: if a Member who does not speak English calls the Customer Service Team for assistance, we will provide an appropriate interpreter to translate for the Customer Service Team representative and the Member.

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



Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

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SECTION 1. DEFINITIONS

This Section lists definitions of words and terms used in this Certificate.

1. GENERAL DEFINITIONS. The following terms, when used in this Certificate and all Amendments, Riders, and Face Sheets thereto, will have the meanings assigned to them below:

1.1 **An Amendment** is any document that describes changes to Basic Health Services or changes to the terms and conditions of coverage, which have become necessary between printings of the Certificate.

1.2 **Basic Health Services** are the medical, hospital and other Covered Services identified as Basic Health Services in this Certificate.

1.3 **Benefit Period** means the period of time this Certificate is in effect as indicated on the Face Sheet.

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

1.5 **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 Review.

1.6 **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).

1.7 **Coinsurance** is a form of cost sharing which requires the Member to pay a specified portion of the cost of Basic or Supplemental Health Services, as set forth on the Face Sheet, after the Deductible has been paid by the Member or Family Unit.

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

1.9 **Complaint** is a dispute or objection regarding a Participating Provider or the coverage operations or management policies of the Plan, which has not been resolved by the Plan and has been filed with the Plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a Grievance.

1.10 **Copayment** is a form of cost sharing which requires the Member to pay an amount of money for the cost of Basic or Supplemental Health Services. Copayment amounts are set forth on the Face Sheet and are due at the time and place such services are received by a Member.

1.11 **Covered Service** means a health care service which is covered by this Plan when it is listed as a Basic Health Service in this Certificate or any Supplemental Health Services as set forth in any Riders attached to this Certificate and is deemed Medically Necessary. Services which are listed as **NOT COVERED** in this Certificate or Riders attached to this Certificate are **NOT COVERED** by this Plan regardless of whether they are deemed Medically Necessary.

1.12 **Creditable Coverage** means the length of time an enrollee had previous continuous health coverage which 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.

1.13 **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.

1.14 **Customer Service Team** refers to the Plan representative who can answer your questions and provide information regarding the Plan. The telephone number is set forth on your Member Identification Card.

1.15 **Deductible** means a specified dollar amount for the cost of Basic Health 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 Face Sheet. 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 Face Sheet and the terms of the applicable Rider. Copayment amounts do not accrue toward satisfaction of any Deductible amounts.

1.16 **Designated Behavioral Health Benefit Program** means a program that has entered into an agreement with the Plan to provide 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 the limitations set forth in this Certificate.

1.17 **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 to which the Member has access. 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.

1.18 **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.

1.19 **Enrollment Application** refers to the Subscriber's written request for enrollment.

1.20 **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 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, 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, 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.

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:

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

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

The improvement in health outcome is attainable outside of the clinical investigation setting; and

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

The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

1.21 **Face Sheet** is a summary of coverage for a Member that identifies the Subscriber, applicable Copayment, Deductible and Coinsurance amounts for Basic Health Services, and any Riders in force for the Certificate. A new Face Sheet will be issued by the Plan when there is a change in any of the information printed on the Face Sheet. A newly issued Face Sheet replaces and supplants all prior Face Sheets as of the effective date printed on the new Face Sheet.

1.22 **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.

1.23 **Family Dependent** means any Member of the family of a Subscriber:

a) who meets all the requirements in 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.

1.24 **Family Unit** means the Subscriber and his Family Dependents.

1.25 **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 CRE review the denial of health care services based on Medical Necessity and appropriateness of care. A Grievance does not include a Complaint.

1.26 **Group** means the employer, association, union or trust through which the Subscriber is enrolled and agrees to remit premiums for coverage payable to the Plan. The Group is identified on the Face Sheet.

1.27 **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 Plan benefits under the terms of this Certificate for persons who meet the requirements of the Group to participate in a program of health service benefits maintained by the Group.

1.28 **Health Care 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 the laws of the Commonwealth of Pennsylvania, 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.

1.29 **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.

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

1.30.1 **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.

1.30.2 **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.

1.30.3 **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.

1.30.4 **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.

1.30.5 **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.

1.30.6 **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.

1.30.7 **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.

1.30.8 **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.

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

1.31 **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.

1.32 **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.

1.33 **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.

1.34 **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 Face Sheet.

1.35 **Maximum Age** means the point in time which a Family Dependent is no longer eligible for coverage, as set forth on the Face Sheet.

1.36 **Medical Director** means the physician (or his designee) designated by the Plan to direct the medical and scientific aspects of the Plan, and to monitor and oversee the appropriate utilization of health services by Members.

1.37 **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, or 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.

1.38 **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.

1.39 **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, except as defined under Sections 5 and 8 of this Certificate.

1.40 **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.

1.41 **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.

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

1.43 **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 2.4.2 hereunder.

1.44 **Pre-Existing Condition** means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan.

1.45 **Primary Care Physician** means a person licensed in the Commonwealth of Pennsylvania as a doctor of medicine or osteopathy (or his 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. The Provider List indicates the current Primary Care Physicians and is updated from time to time.

1.46 **Prior Authorization** means the process by which approval is given by the Plan for Covered Services based on Medical Necessity, eligibility and benefit availability at the time the Covered Services are to be provided prior to the services being performed.

1.47 **Prosthetic Device** means an externally worn appliance or apparatus which replaces a missing body part.

1.48 **Referral** means an authorization by a Participating Provider (generally a Primary Care Physician) for a Member to be evaluated and/or treated by another Participating Provider, prior to such services being performed.

1.49 **Rider** means a document that lists the Supplemental Health Services in effect for the Subscriber and all Family Dependents enrolled under the Certificate, as determined by the Group. All Riders in force under this Certificate are listed on the current Face Sheet.

1.50 **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.

1.51 **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.

1.52 **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.

1.53 **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.

1.54 **Supplemental Health Services** are those benefits provided, in addition to the Basic Health Services, under the Riders listed on the Face Sheet.

1.55 **Tel-A-Nurse** is the twenty-four (24) hour a day toll-free 800 number for Members to access nurse advice. The telephone number is set forth on your Member Identification Card. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.

1.56 **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

This Section explains how to choose a Primary Care Physician, how your Primary Care Physician initiates a Referral and how the Plan gives Prior Authorization for Covered Services.

2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES.

2.1 Satisfactory Relationships. Primary Care Physicians and all physician Participating Providers shall maintain satisfactory physician-patient relationships with Members. Each Primary Care Physician and physician 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 physician Participating Providers are not servants, employees or agents, actual or apparent, of the Plan. In addition, all other Participating Providers are not servants, employees or agents, actual or apparent, of the Plan.

2.2 Choice of Primary Care Physician. Upon enrollment, the Subscriber shall choose a Primary Care Physician for himself and for each enrolled Family Dependent. A Subscriber who fails to choose a Primary Care Physician will be assigned one for himself and each enrolled Family Dependent. 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 Primary Care Physician Benefits. To be covered under the terms of this Certificate, all Covered Services except Emergency Services, obstetrical and gynecological services, mental health services and Substance Abuse services must be delivered, prescribed or referred in advance by the Member's Primary Care Physician.

2.3.1 **Appropriate Referral.** Covered Services not provided by the Member's Primary Care Physician, except Emergency Services, and obstetrical and gynecological services, must be referred, **IN ADVANCE**, as follows:

2.3.1.1 **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 referred 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.

2.3.1.2 **Prior Authorization.** Prior Authorization must be obtained for Covered Services that are not available through a Participating Provider and/or for certain procedures and services designated by the Plan.

2.3.1.3 **Standing Referrals to Specialists.** Standing Referrals for Covered Services for a Member with a life-threatening, degenerative or disabling disease or condition, upon meeting established standards as follows:

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.

2.3.1.4 **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 Referrals for 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.

2.3.1.5 **Access to Mental Health and Substance Abuse Services.** Members may select a provider who participates in the Plan's Behavioral Health Benefit Program to obtain covered services for mental health services and Substance Abuse services without a Referral from the Member's Primary Care Physician.

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

2.4 Continuity of Care.

2.4.1 **Transitional Period.** A new Member, at the Member's option, may 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.

2.4.2 **Termination of Participating Provider or Participating Practitioner Without Cause.** The following definitions **apply only** to Section 2.4.2 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.

2.4.2.1 **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 Member was notified by the Plan of the termination or pending termination of a Participating Practitioner. 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.

2.4.2.2 **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 Member was notified by the Plan of the termination or pending termination. 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.

2.4.3 **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.

2.4.4 **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.

2.5 Refusal To Accept Recommended Treatment/and Advance 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 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 directive; or

c) through a properly appointed surrogate.

2.6 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.

2.6.1 **Cost of Medical Records.** The cost of providing medical records to the Plan, a Primary Care Physician, or a Participating Provider is a covered benefit if the Covered Services received by the Member are Medically Necessary and provided through a Participating Provider or upon Prior Authorization by the Plan.

2.7 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 by the Plan.

c) The Plan's case management nursing staff is available to work with 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 daily review of the Member's care while hospitalized) may be required for inpatient admissions, including emergencies and admissions where the Plan

is not the primary payor. 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. BASIC HEALTH SERVICES

This Section describes those Basic Health Services provided for you by this Certificate. This Section also describes what to do in an emergency or how to arrange for care outside the Service Area.

3. BASIC HEALTH SERVICES. Subject to all terms, conditions and definitions, exclusions and limitations in this Certificate, Members are entitled to receive the FOLLOWING Basic Health Services (and any Supplemental Health Services as set forth in any Riders attached to this Certificate) when Medically Necessary. A Plan Medical Director will be involved in any Plan decision to deny coverage on the basis of Medical Necessity.

Except for Emergency Services and certain Urgent Care, Covered Services are available **only to the extent that they are Medically Necessary and are provided by the Member's Primary Care Physician, the Member's obstetrical or gynecological Participating Health Care Provider, the Member's mental health or Substance Abuse Participating Health Care Provider or upon Referral to a Participating Provider. Covered Services must be provided by Participating Providers except when an emergency makes it impossible to reach a Participating Provider, or when Prior Authorization is obtained because the Member's medical condition requires Covered Services which cannot be provided by Participating Providers.** The continued participation of a Participating Provider cannot be guaranteed by 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 continuation of care provisions set forth in Section 2.4.

Covered Services are subject to the applicable Copayments or Deductible and Coinsurance amounts and benefit maximums specified on the Face Sheet. **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 of this Section and the Certificate, Amendments and any attached Riders will be covered.**

3.1 Hospital Services.

3.1.1 **Benefits.** 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 limitations set forth in this Certificate; radiation therapy; inhalation therapy; cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer; renal dialysis; administration of whole blood and blood plasma and medical social services. Hospital benefits may be provided at a hospital Participating Provider on either an inpatient or outpatient basis or an ambulatory surgical center as authorized in advance by:

a) the Member's Primary Care Physician, the Member's obstetrical or gynecological Participating Health Care Provider (for services within their scope of practice) or the Plan's Designated Behavioral Health Benefit Program within the Service Area; or

b) the Plan for Covered Services not available through a Participating Provider.

Except for mastectomy Covered Services as set forth in Section 3.8, 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

3.1.2 **Copayments.** Each covered day of a hospital stay is subject to the inpatient hospital Copayment as specified on the Face Sheet. Such inpatient hospital Copayment shall be limited to a maximum dollar amount per hospital admission, also on the Face Sheet.

Outpatient surgery/services, including surgery/services in an ambulatory surgical center shall be subject to the outpatient surgery/services Copayment specified on the Face Sheet.

3.2 Physician Services.

3.2.1 **Hospital and Ambulatory Surgical Center.** The following services are Covered Services provided in a hospital or ambulatory surgical center setting, by physician Participating Providers (or other physicians in response to an emergency) including: surgical procedures; anesthesia; and consultation with and treatment by consulting physicians. Such services are provided while the Member is admitted to a hospital as a registered bed patient or is being treated as a hospital outpatient or in an ambulatory surgical center under the orders of a physician. Inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in a medical/surgical unit of an acute hospital are covered; however, inpatient professional services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in a mental hospital or psychiatric unit of an acute hospital are **NOT COVERED** except as may be explicitly provided under the terms of the following three Riders and listed on the current Face Sheet:

a) Mental Health Inpatient and Partial Hospitalization Services;
b) Non-Serious Inpatient Mental Illness Services; and/or
c) Serious Mental Illness Services.

3.2.2 **Physician's Offices**. The following services are Covered Services in a Physician's Office:

a) all diagnostic and treatment services and preventive services listed below under Preventive Services, in this Certificate provided by the Member's Primary Care Physician;

b) cancer chemotherapy and cancer hormone treatments and 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 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. The Plan has the right to require Prior Authorization and/or any additional limitation of any injectable drug at its sole discretion;

d) all diagnostic and treatment services provided in connection with the direct access to obstetrical and gynecological services through a Participating Health Care Provider;

e) diagnostic and treatment Covered Services provided by a Specialist upon Referral by the Member's Primary Care Physician;

f) Medically Necessary Covered Services upon Prior Authorization by the Plan received from physicians who are non-Participating Providers when the Member's medical condition requires Covered Services that cannot be provided through Participating Providers and/or certain procedures and services designated by the Plan.

3.2.2.1 **Copayments.** Applicable Copayments are specified on the Face Sheet. Cancer chemotherapy and cancer hormone treatment shall not be subject to any Copayment amount under this Section.

3.3 Preventive Services. Subject to the cost sharing and benefit maximums as provided in Section 3.3.6, the following preventive health care services are covered when provided:

a) by the Member's Primary Care Physician;

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

c) through another Participating Provider at another location upon Referral by the Member's Primary Care Physician; or

d) by a non-Participating Provider with Prior Authorization by the Plan.

* If a Point of Service Rider is in force with this Certificate, the items listed above in Section 3.3 (a) through (d) do not apply as the Member may utilize additional self-referred services as set forth in the Rider.

3.3.1 **Voluntary family planning services**, including the 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, and services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Certificate in Sections 4.22 and 4.23).

3.3.2 **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 eye and ear examinations to determine the need for vision and hearing correction;

c) for women, annual gynecological examination, including a pelvic examination and clinical breast exam and routine pap smears 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*; and

e) necessary laboratory, X-ray and other diagnostic tests, all as indicated by the age, gender, history and physical examination of Member.

*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.

3.3.3 **Well-child care** from birth.

3.3.4 **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. Pediatric immunizations are exempt from Copayments, Deductibles, Coinsurance or dollar limits, except the office visit Copayment, if applicable. 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 herein.

3.3.5 **Additional Preventive Care Services** as specified on the Face Sheet.

3.3.6 **Copayments and Lifetime Benefit Maximum Amounts.** Applicable Copayment amounts and Lifetime Benefit Maximum amounts for physician office visits, immunizations and diagnostic tests are specified on the Face Sheet.

3.4 Diagnostic Services. Diagnostic tests, services, and materials, including diagnostic radiology and imaging, laboratory tests and electrocardiograms, are covered when referred in advance by the Member's Primary Care Physician or obstetrical or gynecological Participating Health Care Provider (for diagnostic testing related to services within the Participating Health Care Provider's scope of care).

3.4.1 **Genetic Counseling and Testing.** Genetic counseling and testing are covered when authorized in advance by the Member's Primary Care Physician, Participating Provider upon Referral by the Member's Primary Care Physician or obstetrical or gynecological Participating Health Care Provider (for genetic testing related to services within their scope of care) and the Plan. Genetic testing must be in accordance with the Plan's then current genetic testing policies.

3.4.2 **Copayments.** Diagnostic services usually include a charge from the facility where the test is performed and a charge from the physician who interprets or supervises the procedure. Each diagnostic service is subject to the diagnostic services Copayment amount as specified on the Face Sheet.

3.5 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 early discharges. 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. Hospital and physician services required by a newborn child of a Member, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, are covered when ordered or provided by Participating Providers subject to the automatic thirty-one (31) day limitation for newborns. Covered Services provided by a licensed certified nurse midwife Participating Provider shall be covered only if provided in a hospital Participating Provider or an appropriately licensed free-standing birthing center Participating Provider.

3.5.1 **Copayments.** 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 Copayment specified on the Face Sheet. The inpatient hospital Copayment shall be limited to a maximum dollar amount per hospital admission. Postpartum home health care visits within forty-eight (48) hours for early discharges are not subject to any Copayment, Deductible or Coinsurance amount under this Section.

3.6 Oral Surgery. The Plan does **NOT cover general dental services,** defined as operations on or treatment of the teeth and immediately supporting tissues, including correction of malocclusion and/or orthodontia or any ancillary medical procedures required to support a general dental service. The following limited oral surgical procedures, upon Referral by the Member's Primary Care Physician and the Plan, are covered:

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

3.6.2 **Services and supplies necessary for the emergency treatment of trauma to sound, natural teeth.** The need for these services must result from an accidental injury (not chewing or biting)..

3.6.3 **Temporomandibular joint (TMJ) surgery**, limited to correction of dislocation or complete degeneration of the TM joint, consultations to determine the need for surgery and radiologic determinations of pathology.

3.6.4 **Hospital and ambulatory surgical center services and related professional services** provided in connection with a covered or non-covered oral surgery procedure provided on an inpatient or outpatient basis, only if the hospital or ambulatory surgical center services are required for a pre-existing medical condition unrelated to the dental or oral surgical procedure. Such coverage requires Prior Authorization by the Plan.

3.6.5 **Copayments.** Applicable Copayment amounts for oral surgery services will be applied dependent upon the place of setting where such care is rendered and are specified on the Face Sheet.

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

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

3.7.2 **Accidental Injury or Incidental to Surgery.** Upon Prior Authorization by the Plan, covered surgery performed to correct a functional (physiological) defect resulting from accidental injury or incidental to surgery.

3.7.3 **Copayments.** Applicable Copayment amounts for restorative or reconstructive surgery services will be applied dependent upon the place of setting where such care is rendered and are specified on the Face Sheet.

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

3.8.1 **Limitations.** The maximum amount which the Plan will pay for breast prostheses provided hereunder to any one (1) Member is set forth on the Member's Face Sheet.

3.8.2 **Copayments.** Applicable Copayment amounts for post-mastectomy reconstructive surgery services will be applied dependent upon the place of setting where such care is rendered. The applicable Copayment is specified on the Face Sheet.

3.9 Skilled Nursing Facility Services. 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. Such services will be covered upon Referral by the Member's Primary Care Physician and upon Prior Authorization by the Plan. 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.

3.9.1 **Copayments.** Skilled nursing facility services, including physician services, shall be subject to the skilled nursing facility Copayment amount specified on the Face Sheet.

3.10 Rehabilitative Services. Physical, occupational and speech therapy, on either an outpatient or inpatient basis, when service is provided through a Participating Provider, is covered for up to forty-five (45) dates of service per calendar year and is prescribed or approved in advance by the Member's Primary Care Physician, Participating Provider upon Referral by the Primary Care Physician and the Plan.

3.10.1 **Copayments.** Applicable Copayment amounts for rehabilitative services are specified on the Face Sheet.

3.11 Cardiac Rehabilitation. Cardiac rehabilitation on an outpatient basis, when service is provided through a Participating Provider, is covered for up to thirty-six (36) sessions per calendar year.

3.11.1 **Copayments.** Applicable Copayment amounts for cardiac rehabilitation services are specified on the Face Sheet

3.12 Mental Health Services. All 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 Benefit Program.

3.12.1 **Outpatient Professional Mental Health Services.** Mental health services provided on an outpatient basis are covered for up to a maximum of thirty (30) outpatient visits for either individual or group therapy (combined) during each calendar year.

3.12.1.1 **Copayments.** Copayment amounts for outpatient professional mental health services are specified on the Face Sheet.

3.13 Home Health Care. The following home health services are covered when provided in accordance with an approved treatment plan established by a home health agency Participating Provider and a physician Participating Provider. Home health care is covered only in the event a Member is homebound except as provided in Section 3.13.4. 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 3.5.

3.13.1 **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.

3.13.2 **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.

3.13.3 **Other Health Care Personnel.** Medical care in the home is covered provided that the care is given by other health care personnel Participating Providers including but not limited to, speech, physical and occupational therapists under the supervision of physician Participating Providers. This care is covered when it is ordered by the Member's Primary Care Physician or Participating Provider upon Referral by the Primary Care Physician and Prior Authorization by the Plan, subject to the limitations set forth under this Certificate.

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

3.13.5 **Copayments.** Each day of home health care is subject to the Copayment specified on the Face Sheet.

3.14 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 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, subject to Sections 3.14.1(d) and 3.14.2.

3.14.1 **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 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), the Plan's Designated Behavioral Health Benefit Program and the Plan.

3.14.2 **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 at this level only until the Plan determines the Member's condition has stabilized and the Member can be transported to a Participating Provider without suffering detrimental consequences or aggravating the Member's condition.

3.14.3 **Copayments.** Emergency Services are subject to the emergency room Copayment specified on the Face Sheet. 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.

The Specialist Copayment shall apply in lieu of the emergency room Copayment when a Member receives Covered Services in a designated urgent care facility.

3.15 Services Received Outside the Service Area. The following services are covered outside the Service Area:

a) Emergency Services under the same conditions required within the Service Area;

b) Urgent Care 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. 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**. Maternity care for normal term delivery outside the Service Area is **NOT COVERED**; however, treatment of unexpected complications of pregnancy and care for unexpected early delivery are covered as Emergency Services; **AND**

c) Covered Services provided to Members outside the Service Area or by Health Care Providers only with Prior Authorization of the Plan, when the Member's medical condition requires Covered Services which cannot be provided within the Service Area. Requests for coverage must include an explanation as to why the Covered Services cannot be delivered through a Participating Provider or within the Service Area.

3.15.1 **Copayments.** Copayments for services received outside the Service Area will be applied dependent upon the place of setting where such care is rendered. The applicable Copayment amount is specified on the Face Sheet.

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

3.16.1 **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.

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

3.17 Implanted Devices. Surgically implanted devices for purposes of drug delivery and/or contraception as well as cardiac pacemakers and artificial joints, to correct dysfunction due solely to disease or injury and not to psychological causes or sex transformation, are covered upon Referral by the Member's Primary Care Physician.

3.17.1 **Coinsurance.** Surgically implanted devices for purposes of: (i) drug delivery; and/or (ii) contraception are covered subject to the implanted device Coinsurance specified on the Face Sheet. Surgically implanted devices <u>not</u> for purposes of drug delivery and/or contraception (such as cardiac pacemakers and artificial joints) are <u>not</u> subject to the implanted device Coinsurance.

3.18 Podiatry Services. Podiatric 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 4.51.

3.19 Substance Abuse. 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:

3.19.1 **Inpatient/Outpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse, when provided on either an inpatient or outpatient 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.

3.19.1.1 **Copayment and Lifetime Benefit Maximum.** Each 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 Face Sheet as well as Lifetime Benefit Maximums amounts as set forth below. Such inpatient hospital Copayment and Lifetime Benefit Maximum shall be limited to the maximum dollar amount per hospital admission set forth on the Face Sheet. Hospital inpatient detoxification services for Substance Abuse are limited to a total of four (4) admissions per lifetime. Outpatient detoxification services are subject to the Copayment specified on the Face Sheet.

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

3.19.2.1 **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) thirty (30) days per calendar year ; and

b) a total Lifetime Benefit Maximum of ninety (90) days per lifetime.

3.19.2.2 **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: 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. Outpatient rehabilitation services for Substance Abuse shall be limited to:

a) thirty (30) outpatient, full-session visits or equivalent partial visits each calendar year; and

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

3.19.2.3 **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 calendar year; 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.

3.19.2.4 **Copayment and Lifetime Benefit Maximum.** 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. The initial course of treatment shall be subject to the Copayment amounts set forth on the Face Sheet as well as Lifetime Benefit Maximum amounts as set forth in Sections 3.19.2.1, 3.19.2.2 and 3.19.2.3. These amounts shall not be less favorable than those applied to similar classes or categories of treatment for physical illness. Each subsequent course of treatment for a Member shall be subject to the Copayment amounts as set forth on the Face Sheet and Lifetime Benefit Maximum amounts as set forth in Sections 3.19.2.1, 3.19.2.2 and 3.19.2.3.

3.20 Transplant Services and Authorization Requirements. The following services for transplants are covered for certain conditions: hospital charges, physician charges, organ procurement, tissue typing and ancillary services provided for kidney, kidney and pancreas, liver, heart, heart and lung, lung, bone marrow (allogenic and autologous), cornea and stem cell transplants, upon Prior Authorization by the Plan when rendered in a Designated Transplant Facility. **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.**

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.

3.20.1 **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 follow the procedure of requesting a second opinion, outlined in the denial notification. 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. 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.

3.20.2 **Organ Donation.** Covered Services required by a Member as an organ donor for transplantation into another Member are covered upon Prior Authorization by the Plan. 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.

3.20.3 **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 is set forth on the Face Sheet.

3.20.4 **Self-Administered Prescription Drugs.** Except as set forth in this Section 3.20.4, self-administered prescription drugs provided on an outpatient basis to Members are **NOT COVERED** except as may be explicitly provided under the terms of the following four Riders and listed on the current Face Sheet:

a) Outpatient Prescription Drugs with Oral Contraceptives;
b) Outpatient Prescription Drugs without Oral Contraceptives;
c) Outpatient Prescription Drugs with Oral Contraceptives – Triple Choice Benefit; and/or
d) Outpatient Prescription Drugs without Oral Contraceptives – Triple Choice Benefit.

3.20.4.1 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;

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.

Covered Services provided under this Section are subject to the terms and conditions of the Riders indicated above, if applicable and are subject to the applicable Copayment or Coinsurance specified on the Face Sheet.

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

3.21 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) prescribed in advance by a Primary Care Physician, or a physician Participating Provider upon Referral by a Member's Primary Care Physician, and upon Prior Authorization by the Plan;

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.

3.21.1 **Hospice Benefit Election.** The Member shall have the option to elect to receive the Plan's Hospice benefit as set forth in this Certificate, not to exceed three (3) such options during a Member's lifetime. By electing to receive the Hospice benefit, the Member acknowledges that he:

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.

3.21.2 **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 Face Sheet. 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 Members Certificate.

3.22 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.

3.22.1 **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.

3.22.1.1 **Coinsurance.** Diabetic medical equipment shall be subject to the applicable Coinsurance amount specified on the Face Sheet.

3.22.2 **Diabetic Foot Orthotics.** The Plan will cover diabetic foot orthotics when provided by a Participating Provider. Diabetic foot orthotics shall be subject to the diabetic foot orthotic Coinsurance as specified on the Face Sheet.

3.22.3 **Prescription Drugs.** The Plan will cover insulin and oral pharmacological agents for controlling blood sugar as prescribed by a Participating Provider. Prescription drugs shall be subject to the prescription drug Copayment or Coinsurance as specified on the Face Sheet. Disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips) shall be covered and subject to the prescription drug Copayment or Coinsurance as specified on the Face Sheet.

3.22.4 **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.

3.22.4.1 **Copayments.** Applicable Copayment amounts for office visits and outpatient facility services are specified on the Face Sheet.

3.23 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.

3.23.1 **Copayments or Coinsurance.** Applicable Copayment or Coinsurance amounts for enteral feeding/food supplements are specified on the Face Sheet. The cost of these nutritional supplements is exempt from any Deductible provisions listed on the current Face Sheet.

3.24 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.

3.25 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 bariatric center.

3.25.1 Copayment. The applicable Copayment for surgical treatment of morbid obesity is specified on the Face Sheet.

3.26 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.

SECTION 4. EXCLUSIONS

*This Section describes those services that are **NOT COVERED** by the Plan.*
If you receive any services included in this Section, you will be responsible for paying all bills or fees unless a Rider that allows a service is included with this Certificate.

4. EXCLUSIONS. THE FOLLOWING ARE NOT COVERED by the Plan (Unless they are explicitly provided under the terms of a Rider and listed on the current Face Sheet):

4.1 Unauthorized Services. All unauthorized services are **NOT COVERED**. This includes any Basic Health 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 authorization. See Section 3.14 for the Emergency Services protocol.

4.2 Insured Obligations. Amounts for any Covered Service which exceeds the maximum benefit limit set forth on the Face Sheet, or amounts for any Covered Service which are applied toward satisfaction of the Copayment, Deductible or Coinsurance amount.

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

a) an emergency, as provided in Section 3.14;

b) Urgent Care received outside the Service Area, as provided in Section 3.15;

c) Covered Services under this Certificate in accordance with the continuity of care provisions for new and existing Members as provided in Section 2.4; or

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

4.4 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**.

4.5 Covered Services Which Are Not Considered Medically Necessary by the Plan are NOT COVERED.

4.6 Manipulative Treatment Services. Manipulative treatment services are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider(s) terms of the following two Riders and listed on the current Face Sheet:

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

4.7 **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**, except as provided in Section 3.7.1, 3.7.2 or 3.8.

4.8 **Corrective Devices.** The purchase, fitting, or adjustment of corrective devices including but not limited to, eyeglasses, contact lenses, and hearing aids, are **NOT COVERED**.

4. 9 **Prosthetics, Orthotics, Durable Medical Equipment and Medical Supplies.** Prosthetic Devices, Orthotic Devices, durable medical equipment and medical supplies are **NOT COVERED** unless expressly provided for in Sections 3.8 and 3.22 or as may be explicitly provided under the terms of the following three Riders and listed on the current Face Sheet:

a) Durable Medical Equipment;
b) Orthotic Devices-50% Coinsurance; and/or
c) Prosthetic Devices-No Copayment.

.**4.10** **Custodial, Convalescent or Domiciliary Care.** Custodial, Convalescent or Domiciliary Care for which the facilities of an acute general hospital or of a skilled nursing facility are not Medically Necessary, in the judgment of the Plan, are **NOT COVERED**. Custodial, Convalescent, Domiciliary Care or intermediate bed status, in a skilled nursing facility or any other facility is **NOT COVERED**. Home health care for Custodial, Convalescent or Domiciliary care is **NOT COVERED**.

4.11 **Dentistry.** Dental care including, but 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 is **NOT COVERED** unless for expenses otherwise covered on account of accidental injury to otherwise sound natural teeth or as may be explicitly provided under the terms of the following Rider and listed on the current Face Sheet: Impacted Wisdom Teeth.

Implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth are **NOT COVERED**.

4.12 **Maxillary or Mandibular Osteotomies.** Maxillary or mandibular osteotomies are **NOT COVERED**, except when performed to correct dislocation or complete degeneration of the TM joint, as provided for in Section 3.6.3.

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

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

4.15 **Sex Transformation.** Transplants, implants, procedures, services and supplies related to sex transformation are **NOT COVERED**.

4.16 **Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate at Sections 3.20 and 3.22 or as may be explicitly provided under the terms of the following four Riders and listed on the current Face Sheet.

a) Outpatient Prescription Drugs with Oral Contraceptives;
b) Outpatient Prescription Drugs with Oral Contraceptives – Triple Choice Benefit;
c) Outpatient Prescription Drugs without Oral Contraceptives; and/or
d) Outpatient Prescription Drugs without Oral Contraceptives – Triple Choice Benefit.

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

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

4.19 **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.

4.20 **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**.

4.21 **Refractions.** Examinations to determine the refractive error of the eye are **NOT COVERED** unless expressly set forth in this Certificate; or as may be explicitly provided under the terms of the following Rider and listed on the current Face Sheet: Refractions.

4.22 **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**.

4.23 **Drugs and Devices for Purposes of Contraception.** Drugs and devices for purposes of contraception are **NOT COVERED** except: (i) implanted devices as provided for under Section 3.17 of this Certificate; or (ii) as may be explicity provided under the terms of the following two Riders and listed on the current face sheet:

a) Outpatient Prescription Drugs with Oral Contraceptives; and/or
b) Outpatient Prescription Drugs with Oral Contraceptives – Triple Choice Benefit.

4.24 **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**.

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

4.26 **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 three Riders and listed on the current Face Sheet:

a) Mental Health Inpatient and Partial Hospitalization Services;
b) Non-Serious Inpatient Mental Illness Services; and/or
c) Serious Mental Illness Services.

4.27 **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 three Riders and listed on the current Face Sheet:

a) Mental Health Inpatient and Partial Hospitalization Services;
b) Non-Serious Inpatient Mental Illness Services; and/or
c) Serious Mental Illness Services.

4.28 **Mental Health Inpatient Professional Services.** Mental Health Inpatient Professional Services provided by a licensed psychiatrist or clinical psychologist are **NOT COVERED** unless expressly set forth in Section 3.2.1 or as may be explicitly provided under the terms of the following three Riders and listed on the current Face Sheet:

a) Mental Health Inpatient and Partial Hospitalization Services;
b) Non-Serious Inpatient Mental Illness Services; and/or
c) Serious Mental Illness Services.

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

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

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

4.32 **Vein Sclerosing and Vein Stripping.** 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.

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

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

4.35 **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.

4.36 **Panniculectomy, Lipectomy, Liposuction, Abdominoplasty.** Excision of excessive skin and subcutaneous tissue including but not limited to (1) panniculectomy (abdominoplasty) or (2) lipectomy by any method (suction assisted, liposuction, 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, hips and other areas not specifically listed.

4.37 **Genetic Counseling and Testing.** Genetic counseling and testing are **NOT COVERED** unless expressly set forth in Section 3.4.1.

4.38 **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.

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

4.40 **Hypnosis.** Hypnosis is **NOT COVERED**.

4.41 **Weight Control.** Weight reduction programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.26.

4.42 **Transportation Services.** Stretcher/wheelchair van transportation and transportation services for convenience are **NOT COVERED**.

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

4.44 **Travel Expenses for Transplant Services.** Travel expenses for transplant services are **NOT COVERED.**

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

4.46 **Splints for TMJ Conditions.** Splints for TMJ conditions are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider and listed on the current Face Sheet: Orthotic Devices – 50% Coinsurance.

4.47 **Biofeedback.** Biofeedback is **NOT COVERED**.

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

4.49 **Sexual Dysfunction Services, Devices and Equipment.** Sexual dysfunction services, devices and equipment, male or female, are **NOT COVERED** except as may be explicitly provided under the terms of the following two Riders and listed on the current Face Sheet:

a) Orthotic Devices – 50% Coinsurance and/or
b) Prosthetic Devices-No Copayment.

4.50 **Acupuncture.** Acupuncture is **NOT COVERED**.

4.51 **Podiatry Services.** Treatment of bunions (except capsular or bone surgery), corns, calluses, warts, fallen arches, flat feet, weak feet, chronic foot strain (except for diabetic conditions) is **NOT COVERED**.

4.52 **Services Provided by a Member's Relative or Self.** Services rendered by a person who is the spouse, child, parent or sibling of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.

4.53 **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 Sections 3.12.

4.54 **Mental Health or Substance Abuse Services Obtained From a Provider Who Does Not Participate in the Plan's Designated Behavioral Health Benefit Program.** 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**.

4.55 **Certain Covered Services for Which Prior Authorization is Required But Not Obtained.** Certain designated Covered Services for which Prior Authorization is required but not obtained prior to the provision of such services are **NOT COVERED**.

4.56 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**.**

SECTION 5. COMPLAINT AND GRIEVANCE PROCEDURE

This Section describes your rights if you believe you have not received the benefits or services to which you are entitled. The Plan maintains Complaint and Grievance processes each involving two (2) levels of review. In addition the Member has the opportunity to appeal the decision to an external review process.

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 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; 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 at 1-800-447-4000, Monday through Friday between the hours of 8:00 a.m. to 5:00 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.

Complaint means a dispute or objection by a Member regarding a Participating Health Care Provider, or the coverage (including contract exclusions and non-Covered Services), operations or management policies of the Plan, that has not been resolved by the Plan.

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 concern 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.

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.

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.

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. 3020, 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.

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.

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.

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.

Grievance means a request by a Member or a Health Care Provider (with the written consent of the Member) to have the Plan reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. 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.

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. 3020, 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.

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.

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.

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.

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.

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.

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 timeframe 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.

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.

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

This Section describes the requirements each Member and their dependents must meet in order to be covered by this Plan.

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 Face Sheet.

A dependent child is:

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, except a Family Dependent 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.

6.2.1 **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.

6.2.2 **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.

6.2.3 **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.

6.2.4 **Children Born To Family Dependents.** A child born to a Family Dependent is automatically covered under this Certificate for thirty-one (31) days from the date of birth. 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.

6.2.5 **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 order to continue coverage of a disabled dependent child, the Subscriber must provide evidence of the child's incapacity and dependency to the Plan within thirty-one (31) days of the date the child's coverage would otherwise terminate. 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.

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.

6.2.6 **Students.** The Face Sheet 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 Face Sheet, or upon the date on which the Plan is first notified of such enrollment.

6.2.6.1 **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 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 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 **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.

For COBRA-eligible Groups, the following Section 6.3 shall apply;

6.3 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 Group coverage 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. 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 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:

6.4.1 **Open Enrollment Period.** 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.

6.4.2 **Other Time.** 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 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. Coverage for individuals who fail to enroll during the Open Enrollment Period or within thirty-one (31) days of initially attaining eligibility shall NOT be eligible to enroll until the next Open Enrollment Period.

6.5 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.

6.6 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.

6.6.1 **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 continuation of benefit period (for 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.

For employer Groups, a Pre-Existing Condition exclusion may apply as follows:

6.7 Pre-Existing Condition Exclusion. Coverage for Pre-Existing Conditions shall begin after the Member has been covered under the 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 was covered under another comprehensive group or individual health plan. 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.

6.7.1 **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 a diagnosed condition); or

i) to Members for whom this Certificate replaces prior group coverage that did not contain the pre-existing condition exclusion.

6.7.2 **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 Identification Card.

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

6.9 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.

6.10 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.

SECTION 7. PAYMENT PROVISIONS

This Section describes the method of payment for your Plan.

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. 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 make any required Copayment, Deductible or Coinsurance amount on behalf of himself or any Family Dependent incurred during the grace period.

SECTION 8. LIMITATIONS

This Section describes the conditions that may restrict the benefits of this Plan.

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) This Coordination of Benefits (COB) provision applies to This Plan when a Member has health care coverage under This Plan and one or more other Programs.

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

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

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

8.2.3 **Order of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

iv) Provided, however, 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 **Medicare Enrollment Not Required.** Except as set forth in this Certificate, Subscribers who are enrolled as employees under an employee health benefit plan maintained by a Group, and who are age 65 or older (including Family Dependents of such a Subscriber who is age 65 or older), are not required to be enrolled in Medicare to continue enrollment under this Certificate. This Plan is primary with respect to Medicare for a Subscriber who is enrolled as an employee of the Group, and for Family Dependents of that Subscriber, regardless of the Medicare status of such Members.

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

This Section describes the reasons that allow the Plan or your employer to discontinue coverage.

9. TERM AND TERMINATION.

9.1 Term. The effective date of this Certificate is stated on the Face Sheet. 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 reapply with the Plan within thirty-one (31) days of the date of notification of termination, reapplication and submission of evidence of insurability by the Member to the Plan will be required.

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.

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.

A Member whose coverage is terminated under this Section for fraud or material misrepresentation may not reapply 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. Members whose coverage is terminated pursuant to this Section are not eligible for conversion to individual, direct payment coverage where there is a succeeding or alternate carrier. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 9.6.

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.

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) or as otherwise set forth 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 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.

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 the use of the Plan's internal Complaint procedure.

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 (for COBRA eligible Groups) are eligible for conversion coverage when their 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.

9.3.12 **Continuation of Group Coverage Under Federal Law (COBRA).** A Member may be able to continue group coverage under this Certificate for a limited time after coverage terminates, if required by federal COBRA law. The Member should contact the Group to learn how to elect COBRA coverage or how much to pay the Group for it.

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; or

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 the maximum amount of benefits has been paid; or
3) until the Member becomes covered without limitation as to the condition for which he or she is receiving inpatient care under any other group coverage; or
4) up to the end of the Benefit Period;

whichever comes first.

In the event of termination of this Contract because of termination of active employment, the Covered Services will be provided during total disability with respect to the sickness or injury which caused the disability for twelve (12) months, 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.

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. Ordinarily, Members should not receive bills (invoices, statements) from Participating Providers of Covered Services under this Certificate unless due to a clerical error on the part of a Participating Provider. Members will be billed for Covered Services from non-Participating Providers.

10.3.1 **Proofs of Loss.** 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 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. By 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 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 incident 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. 3020
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 Member 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.

EXHIBIT 1
GEISINGER HEALTH PLAN
SERVICE AREA

SERVICE AREA shall mean the following counties located in Pennsylvania: 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, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York.

(In Bedford, Cumberland, Elk, Perry and Potter 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

CUMBERLAND COUNTY
- the following zip codes only:
17001
17007
17008
17011
17012
17013
17025
17027
17043
17050
17055
17065
17072
17081
17089
17091
17093
17218
17324
17375

ELK COUNTY
- the following zip codes only:
15821
15822
15823
15827
15831
15841
15846
15860
15868

PERRY COUNTY
- the following zip codes only:
17020
17024
17031
17037
17040
17045
17053
17062
17068
17069
17074
17090

POTTER COUNTY
- the following zip codes only:
17729

Notes

Notes

Notes

Notes

HMO
Summary of Benefits
Citigroup 2008

SERVICES covered when medically necessary	You Pay
Outpatient Services	
Routine office visits.	$15
Specialist office visit with referral.	$25
Periodic health assessments/routine physicals.	$15
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0
Outpatient surgery.	$100
Well-Baby Care	
Office visits, including well-child care.	$15
Pediatric immunizations and inoculations.	$0
Testing Services	
X-rays, laboratory and other diagnostic tests.	$0
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan).	$0
Well-Woman Care	
Annual gynecological examination, including pelvic examination and routine pap smears. Includes appropriate follow-up care and referrals for diagnostic testing and treatment services relating to gynecological care. No referral required.	$15
Annual mammogram for women forty (40) years of age and older.	$0
Maternity Care	
Maternity care by your physician before and after the birth of your baby. No referral required.	$15 for first visit only subsequent visits covered 100%
Hospitalization	
Care in a semi-private room at a Plan-approved facility. Includes intensive care, cardiac care unit services, obstetrical care, medications and diagnostic tests.	$400/admission
Medical and surgical specialist care, including anesthesia.	$0
Surgery for Correction of Obesity	
Facility charges.	$2,000
Emergency Services	
Emergency care.	$50 (waived if admitted to hospital)
Emergency ambulance transportation.	$0
Critical response air transport.	$0
Rehabilitation Services	
Physical therapy, speech therapy, occupational therapy, for up to 45 dates of service per calendar year.	$25
Cardiac rehabilitation, outpatient, up to 36 sessions/year. Requires prior Plan approval.	$0
Diabetes Services and Supplies[1]	
Prescription/supply coverage: Lifescan test strips, 34-day supply per copayment (One-Touch, One-Touch Ultra, Surestep and FastTake) and lancets are covered. The following may be limited to specific vendors: insulin, syringes and needles for the administration of insulin only, oral agents used to control blood sugar (1 copayment/34 day supply) and Glucagon emergency kit (two per copayment).	Tier 1: $10 for 34-day supply Tier 2: $20 for 34-day supply Tier 3: $50 for 34-day supply
Diabetic foot orthotics.	$0
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0
[1]The Plan reserves the right to restrict vendors and apply quantity limitations.	
Skilled Nursing/Home Health Services	
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.	$0
Home health care by primary care physician.	$15
Home health care by specialist.	$25
Home health care by other participating skilled professional.	$0

Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services. $10,000 lifetime maximum per member.	$0
Breast Prosthetic Benefit - Limit $1,000 per breast	$0
Implanted Devices	50%
Alcohol and Drug Abuse Treatment[2]	
Inpatient detoxification. Lifetime limit: 4 admissions.	$400/admission
Outpatient detoxification.	$0
Non-hospital residential inpatient rehabilitation; up to 30 days/year. Lifetime limit: 90 inpatient days.	No copay for initial course of rehabilitation. 50% copayment applies to second and subsequent episodes of care.
Outpatient rehabilitation at an alcoholism/drug abuse facility up to 30 visits/year. An additional 30 visits are available if authorized by the primary care physician, which can be exchanged two visits for one day of inpatient rehabilitation services. Lifetime limit: 120 outpatient visits.	No copay for initial course of rehabilitation. 50% copayment applies to second and subsequent episodes of care.
[2]No PCP referral required. Services must be provided by facilities participating with United Behavioral Health (UBH). Call UBH at (888) 839- 7972 for more information. Pre-authorization by UBH is required for all services except routine outpatient visits.	
Mental Health[3]	
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional: 30 outpatient visits (55-minute) per calendar year.	$25 copay/individual therapy visit $10 copay/group therapy session
[3]No PCP referral required. Services must be provided by facilities participating with United Behavioral Health (UBH). Call UBH at (888) 839- 7972 for more information. Pre-authorization by UBH is required for all services except routine outpatient visits.	
Serious Mental Illness (SMI) Rider[4]	
Care provided for the following serious mental illnesses: schizoprenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Care for these conditions by a participating provider facility: up to 30 inpatient days per calendar year and 60 outpatient visits per calendar year. Conversion option: 1 inpatient day (SMI) to either 2 outpatient visits or 2 partial hospitalization days.	$400/admission inpatient facility copay $25 copay/inpatient professional visit $25 copay/partial hospitalization day
[4]No PCP referral required. Services must be provided by facilities participating with United Behavioral Health (UBH). Call UBH at (888) 839- 7972 for more information. Pre-authorization by UBH is required for all services except routine outpatient visits.	

Supplemental benefits through "RIDERS"	**You Pay**
Non-Serious Mental Illness Rider	
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulemia nervosa, schizo-affective disorder and delusional disorder. Care for acute short-term psychiatric conditions in a participating provider facility: up to 30 inpatient days per calendar year (subject to a limit of 30 inpatient days per admission). Conversion option: 1 inpatient day for 2 partial hospitalization days. Lifetime limit: 90 inpatient mental health days or 180 partial hospitalization days. No PCP referral required. Services must be provided by facilities participating with United Behavioral Health (UBH). You must receive pre-authorization by calling UBH at (888) 839-7972.	$400/admission inpatient facility copay $25 copayment/professional visit $25 copayment/partial hospitalization per day
Eye Exams	
One eye exam per year to determine the refractive error of the eye. No PCP referral required.	$0
Durable Medical Equipment	
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor, up to $2,500 per member per calendar year. The Plan reserves the right to restrict vendor.	$0
Prosthetic Devices	
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Plan pays up to $5,000 per member per calendar year. Medically necessary replacements covered every 5 years.	$0
Orthotic Devices	
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50% coinsurance
Impacted Wisdom Teeth Extraction	
Oral surgery by participating provider for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered.	$0
Triple Choice Option for Outpatient Prescription Drugs[5]	
34-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug assigned to a tier. Tier 1: most generic drugs; no prior authorization required. Tier 2: certain formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents and other brand name drugs, including some not listed on the formulary; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988- 4861.	Tier 1: $10 for 34-day supply Tier 2: $20 for 34-day supply Tier 3: $50 for 34-day supply

Oral contraceptives; includes diaphragms.	Copayment amount depends on tier for 30-day supply
Mail Order Pharmacy. Prescriptions can be received through the mail by using the Plan's mail order pharmacy program. A doctor's prescription, copayment and completed form is required.	2 flat copays amount(s) depending on tier/90-day supply
[5]The Plan reserves the right to restrict vendors and apply quantity limitations.	
Therapeutic Adjustment Services	
Manipulative treatment, electrical stimulation-attended, ultrasound, exercise therapy for strength and endurance and range of motion, re-education posture and proprioception, and exercise therapy to improve functional performance. Services must be performed by a participating provider. Maximum: 15 visits/calendar year.	$15
Please review individual rider documents for limitations and exclusions.	

Member Information

We want our members to be well informed. The following information is available by contacting our Customer Service Team at (800) 447-4000.

- Geisinger Health Plan Board of Directors
- Summary of provider reimbursement methodologies
- Provider List and/or monthly Provider List Updates
- Description of process for Formulary exception
- Procedures for covering experimental drugs/procedures
- Pharmacy formulary
- Provider credentialing process
- Summary of quality assurance program
- Provider privileges at contracted hospitals

Important information, definitions, and limitations

Case Management: a service where Plan nurses assist members with serious conditions to obtain appropriate support and services so that members can achieve their optimal level of health.

Concurrent review: a process to ensure that medically necessary, appropriate care is delivered to a hospitalized member.

Confidentiality: the Plan's confidentiality policy protects members' privacy of their personal health information including medical records, claims, benefits and other administrative data in all settings. The policy also prohibits sharing personal health information with employers including fully insured employers. However, as a member you always have access to your medical records. Upon enrollment, members sign routine consent forms which allow the Plan to use your information to conduct its business like paying claims and for measurement of data where members identifiers are removed to assure confidentiality. For release of any other personal information, except when required by law, you will be asked to sign a special consent form. A complete copy of the confidentiality policy is available by contacting the Customer Service Team.

Continuity of care for new members (Act 68): Under the provisions of Act 68, a new member can continue on-going treatment with a non-participating physician for the first 60 days of enrollment. If a member is in her second or third trimester of pregnancy, services will be covered through delivery and postpartum care. To initiate this request, the member must contact the Customer Service Team prior to receiving treatment. The Plan will confer with the provider to determine if the provider will accept the Plan's terms and conditions for payment. If the provider does not agree, the services of the non-participating provider will not be covered.

Covered services: that are not available from the member's PCP but are available within the Plan's network must be authorized in advance by your PCP, with the exception of obstetrical or gynecological services for which you may self-refer. Mental health and substance abuse services require prior authorization from United Behavorial Health. Covered services that are not available within the Plan's network or are out of the Plan's service area must be authorized in advance by the Plan.

Medical Necessity or Medically Necessary: covered services rendered by a health care provider that the Plan determines are: a) appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; b) provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease or injury; c) in accordance with current standards of medical practice; d) not primarily for the convenience of the member, or the member's provider; and e) the most appropriate source or level or 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.

Prior authorization: the process by which approval is given by the Plan for covered services based on medical necessity, eligibility and benefit availability at the time the covered services are to be provided prior to the services being performed.

PCP: primary care physician.

Retrospective review: to determine the appropriateness of treatment, the Plan will complete a post-clinical review when necessary to determine whether or not the treatment met coverage guidelines. Based on this review, claims associated with treatment will be approved or denied.

This document is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the Subscription Certificate and applicable riders under which a member is enrolled. This managed care plan may not cover all your health care expenses. Read your Subscription Certificate and riders carefully to determine which health care services are covered.

The following services are not covered under the benefits provided: * Acupuncture * Amounts that exceed the maximum benefit limit * Antihemophilic agents unless specified in a supplemental rider * Any type of services, supplies or treatments not specificaly provided for in the Subscription Certificate and riders * Artifically created blood products * Batteries required for diabetic medical equipment * Benefits for persons whose permanent residence is outside the Plan service area * Biofeedback * Care for covered services that state or local law requires to be treated in a public facility * Care for military service connected disabilities for which the member is legally entitled to covered services and for which facilities are accessible to the member * Care related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavorial problems and mental retardation, which extends beyond traditional medical management * Charges of missed appointments by the member * Charges to the extent payment has been made under Medicare when Medicare is the primary carrier or by any other federal, state or local government program * Custodial, domiciliary or convalescent care for which the facilities of acute general hosptial or of a skilled nursing facility are not medically necessary * Dental care including but 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 * Drugs and devices for contraception, except implanted devices, or as may be covered under a supplemental rider * Drugs and prescribed medications provided on a daily basis, unless specifically covered under a supplemental rider * Drugs, services, supplies or treatments for which the member whould have no obligation to pay * Elective abortion * Enternal feeding and food supplements except as expressly covered for certain diagnosis * Expenses associated with surrogate motherhood * Experimental medical or surgical procedures as determined by the Plan * Genetic counseling and testing * Hair removal * Hospital or ambulatory surgical center services to manage a member solely on the basis of the member's age * Hypnosis * Implants, bridges, crowns & root canals * Infertility procedures * Maxillary or mandibular osteotomies * Mental health inpatient and partial hospitalization services unless specified in a supplemental rider * Non-emergency services or supplies received from non-participating providers * Obesity surgery and podiatric services are not covered when a member self-refers * Organ donation to non-members * Orthoptic therapy * Personal comfort items in the hospital (such as radio, television, telephone and special meals) * Physical, psychiatric or psychological examinations, diagnostic testing, reports, vaccinations, or immunizations for a third party which are not medically necessary * Podiatry services as follows: treatment of bunions except capsular or bone surgery, corns, calluses, warts, fallen arches, flat feet, foot strain (except for diabetic conditions) * Private duty nursing * Procedures, services and supplies related to sex transformations * Prosthetics, orthotics, durable medical equipment and medical supplies unless specified in a supplemental rider * Refer to supplemental riders for a complete description of covered and non-covered services * Reversal of sterilization * Routine nail trimmings * Services provided by a member's relative * Services required as a result of a member's participation in a riot or insurrection * Services required as a result of commission or attempted commission of a felony by the member * Sexual dysfunction services, devices and equipment * Splints for TMJ conditions * Storage of blood including autologous blood and cord blood * Stretcher/wheelchair van transportation and transportation services for convenience * Surgery for the removal of excessive skin and its subcutaneous tissue, revision of external ear, vein sclerosing and stripping and breast reduction * The purchase, fitting, or adjustment of corrective devices including but not limited to eyeglasses, contact lenses and hearing aids * Travel expenses for transplant services * Weight reduction programs for non-morbid obesity, except as offered by the Plan's designated vendor * When self-referred in or out -of-network: implanted devices for drug delivery and contraception; organ, bone marrow, stem cell or corneal transplants, evaluations and related services * Whole blood and blood plasma * Refractions unless specified in a supplemental rider * Chiropractic services unless specified in a supplemental rider * Cosmetic or reconstructive surgery, unless deemed medically necessary to restore normal physiological function

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GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Durable Medical Equipment

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate or Agreement on the current Face Sheet of which it is currently listed as being in force. Durable Medical Equipment must be obtained from a Participating Provider.

1. **DEFINITIONS.**

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

1.2 **"Participating Provider"** means a licensed supplier of Durable Medical Equipment which has, in effect on the date of service, an agreement with the Plan to provide Standard Durable Medical Equipment, as defined in Sections 1.3 and 1.5 of this Rider, to Members under the provisions of this Rider, and is so designated by the Plan.

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

1.4 "**Related Supplies**" means medical supplies required to support the use of covered Durable Medical Equipment.

1.5 **"Standard"** means possessing 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.

1.6 **"Prosthetic Device"** means an externally worn appliance or apparatus which replaces a missing body part.

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

2. **BENEFITS.**

2.1 **Durable Medical Equipment and Related Supplies.** Subject to the Copayments and Limitations set forth in this Rider, the Plan will pay for the cost of renting, or at its option, purchasing Medically Necessary Standard Durable Medical Equipment and Related Supplies as further set forth in Section 2.1.1 hereof, when prescribed in advance for use consistent with required Food and Drug Administration (FDA) approved labeling for the item by a Primary Care Physician, or a Plan Physician upon Referral by a Member's Primary Care Physician, and upon Prior Authorization by the Plan. Coverage for Medically Necessary Standard Durable Medical Equipment will be based upon the coverage criteria as set forth in the current Durable Medical Equipment Regional Carrier (DMERC) policy. This benefit includes the cost of delivery and installation. Repair and replacement of Durable Medical Equipment is covered only to the extent required as a result of normal wear and tear. Durable Medical Equipment must be obtained from a Participating Provider. The Plan reserves the right to recover any Durable Medical Equipment 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.

2.1.1 This benefit is limited to the following types of Durable Medical Equipment:

Ambulatory Assistive Devices – Canes, Crutches, Walkers;

Apnea Monitors;

Continuous Passive Range of Motion Devices;

Dynamic Splinting Devices;

Enuresis Alarms;

External Cardiac Defibrillator Devices;

Manual Wheelchair and Medically Necessary Attachments Such as Anti-Tip Devices, Reclining Back;

Negative Pressure Wound Therapy and Related Equipment (Canisters, Dressings);

Neuromuscular Electrical Stimulation Devices (NMES) For Disuse Atrophy;

Non-Electric, Hydraulic Patient Lifts and Slings;

Non-Implanted, Non-Invasive Osteogenesis Stimulators, Spinal and Non-Spinal;

Oxygen and Oxygen Equipment Including Humidification;

Pediatric Prone Standers, Gait Trainers;

Photo Therapy (Bilirubin) Lights;

Pneumatic Compression Devices and Required Sleeves;

Portable Bedside Commodes;

Respiratory Equipment Including Assistive Devices – CPAP, BIPAP and IPPB; Percussors and Humidification; Mechanical Ventilators; High Frequency Chest Wall Oscillation Air Pulse Generator Systems for Airway Clearance; Nebulizers – Non-Disposable, Air Compressors with Nebulizers as Indicated;

Semi-Electric Hospital Bed and Medically Necessary Accessories Such as Trapezes, Pressure Reducing Support Surfaces (Gel or Water Cushions, Alternating Pressure Pads);

Suction Pumps;

Traction Devices – Cervical, Lumbar, Over Door, Extremity Frames and Stands;

Transcutaneous Electrical Stimulation (TENS) Units

3. **COPAYMENTS.**

3.1 **Copayments.** The Plan will pay 100% of the cost of rental or purchase, up to the maximum benefit limit set forth in Section 4.1 of this Rider.

4. **LIMITATIONS.**

4.1 **Maximum Benefit.** The maximum amount which the Plan will pay for all benefits provided under this Rider to any one Member in a calendar year is set forth on the Face Sheet. Members must pay any remaining amounts above this maximum.

5. **EXCLUSIONS.** The following are **NOT COVERED** under this Rider:

5.1 More than one piece of equipment that serve the same function, including rental or back up of owned or rented equipment.

5.2 Motor driven or deluxe equipment of any sort, or equipment which has been otherwise determined by the Plan to be non-standard.

5.3 Items which are primarily for personal comfort or convenience, including but not limited to bedboards, air conditioners, and over-bed tables.

5.4 Air filtration units, vaporizers, heating lamps or pads, pillows, cushions, hypoallergenic sheets, paraffin baths.

5.5 Disposable supplies, such as soft collars, elastic bandages, support stockings, ostomy supplies, self-administered catheters, spacer devices for meter dose inhalers, peak flow meters or incentive spirometers. (Supplies administered during a covered physician office visit are covered as part of the visit under the Certificate or Agreement.)

5.6 Anodyne infrared therapy.

5.7 Exercise equipment such as whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools, saunas and seasonal affective disorder lights.

5.8 Self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides.

5.9 Communicative equipment or devices, computerized assistive devices and communication boards.

5.10 Experimental or research equipment which is not accepted as Standard medical treatment of the condition being treated, as determined by the Plan, or any such item requiring Federal or other governmental agency approval not granted at the time Durable Medical Equipment was rendered. The experimental or nonexperimental nature of any Durable Medical Equipment shall be determined by the Plan.

5.11 Repair or replacement of any piece of equipment, such as for loss, theft, misuse, except as specifically provided for in Section 2.1.

5.12 Any piece of equipment which is determined by the Plan to be no longer Medically Necessary.

5.13 Motor vehicles, or any modification to any vehicle including but not limited to car seats.

5.14 Access ramps for home or automobile.

5.15 Hearing aids, hairpieces and wigs, eyeglasses and/or contact lenses.

5.16 Breast pumps.

5.17 Batteries.

5.18 Diabetic medical equipment, including blood glucose monitors, insulin infusion devices, insulin pumps and injection aids (including needle-free injection devices, penlet devices, insulin pens, bent set for insulin pump infusion and non-needle cannula for insulin infusion) which is covered as a Basic Health Service under the Certificate or Agreement.

5.19 Mastectomy bras.

5.20 Continuous hypothermia machine cold therapy, ice packs.

5.21 Vitrectomy face support devices.

5.22 Prosthetic or Orthotic devices.

5.23 Home monitoring equipment other than those listed in 2.1.1., such as home INR testing devices or adult (greater than age 17) pulse oximeter.

5.24 DME which is supplied by a provider that is not Participating unless approved in advance by the Plan.

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Impacted Wisdom Teeth

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet of which it is currently listed 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 a medical condition unrelated to the dental or oral surgical procedure. Such coverage must be authorized in advance by the Medical Director.

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 a pre-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.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Manipulative Treatment Services

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet of which it is currently listed as being in force. Services must be obtained from Participating Providers.

1. **BENEFITS**.

1.1 **Manipulative Treatment Services**. Subject to the Copayments as set forth in the Face Sheet and the Limitations set forth in this Rider, the Plan will pay the cost of 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 Medical Director. 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. **COPAYMENT and LIMITATIONS**.

2.1 Manipulative treatment services are subject to the Primary Care Physician office visit Copayment, as set forth on the Face Sheet of the Certificate to which this Rider is attached.

2.2 Manipulative Treatment **Services Benefit Maximum.** Manipulative treatment services provided under this Rider to any Member shall be limited to fifteen (15) visits each calendar year. Members must pay for any Manipulative treatment Services received above this maximum.

3. **EXCLUSIONS.**

3.1 Manipulative treatment services that are not obtained from Participating Providers are **NOT COVERED.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Non-Serious Inpatient Mental Illness Services

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet of which it is currently listed as being in force. Services must be obtained from Participating Providers in the Plan's Designated Behavioral Health Benefit Program.

1. DEFINITIONS.

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.

1.2 **"Non-Serious Mental Illness Lifetime Benefit Maximum"** means the lifetime benefit maximum amount the Company will cover under this Rider as set forth below.

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 for up to thirty (30) inpatient days per calendar year, subject to a limitation of thirty (30) inpatient days per admission.

2.1.1 **Partial Hospitalization.** One (1) covered inpatient day for the treatment of Non-Serious Mental Illness may be converted into two (2) days of care for the treatment of Non-Serious Mental Illness provided through a partial hospitalization program by a provider who participates in the Plan's Designated Behavioral Health Program. The cost of services provided through a partial hospitalization (psychiatric day-care) program, where available, is covered for up to sixty (60) days per calendar year.

2.2 **Non-Serious Mental Illness Lifetime Benefit Maximum.** There is a Non-Serious Mental Illness Lifetime Benefit Maximum of the equivalent of ninety (90) inpatient Non-Serious Mental Illness days or one hundred eighty (180) partial hospitalization Non-Serious Mental Illness days. The Non-Serious mental Illness Lifetime Benefit Maximum will be calculated by converting one (1) covered inpatient Non-Serious

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Mental Illness day into two (2) days of care for the treatment of Non-Serious Mental Illness provided through a partial hospitalization program as described hereinabove.

2.3 **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. COPAYMENT.

3.1 Mental health inpatient services are subject to the applicable Copayment amounts as set forth on the Face Sheet. Partial hospitalization services for the treatment of Non-Serious Mental Illness are subject to the applicable Copayment as set forth on the Face Sheet.

4. EXCLUSIONS.

4.1 **Non-Serious Mental Illness Services**. Non-Serious Mental Illness services obtained from Providers who do not participate in the Company's Designated Behavioral Health Program are **NOT COVERED.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Orthotic Devices – 50% Coinsurance

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate or Agreement on the current Face Sheet of which it is currently listed as being in force. Orthotic Devices must be obtained from a Contracted Vendor.

1. **DEFINITIONS.**

   1.1 **"Contracted Vendor"** means a licensed supplier of orthotics which has, in effect on the date of service, an agreement with the Plan to provide Standard Orthotic Devices, as defined in Sections 1.2 and 1.3 of this Rider, to Members under the provisions of this Rider, and is so designated by the Plan.

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

   1.3 **"Standard**" means possessing qualities or attributes which are determined by the Plan to be: (i) in accordance with Medicare's then current medical necessity coverage criteria; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available.

2. **BENEFITS.**

   2.1 **Orthotic Devices**. Subject to the Copayments and Limitations set forth in this Rider, the Plan will pay for the purchase of Standard Orthotic Devices, when prescribed in advance by a Primary Care Physician, a Participating Provider physician on referral by a Primary Care Physician, or when approved in advance by the Plan. Standard Orthotic Devices must be obtained from a Contracted Vendor unless authorized in advance by the Plan.

3. **COPAYMENTS AND LIMITATIONS.**

   3.1 **Copayments**. The Plan will pay 50% of the cost of purchase of Standard Orthotic Devices.

   3.2 **Limitations**. The Plan reserves the right to restrict the manufacturer of Standard Orthotic Devices 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. **EXCLUSIONS**. In addition to the exclusions set forth in the Certificate, the following are **NOT COVERED** under this Rider.

   4.1 Deluxe appliances or apparatuses of any sort, or appliances or apparatuses which have otherwise been determined by the Plan to be non-Standard.

   4.2 Items which are primarily for personal comfort or convenience.

4.3 Disposable supplies including, but not limited to, support stockings, gloves, and ace bandages.

4.4 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 Basic Health Service under the Certificate or Agreement.

4.5 Experimental or research equipment which is not accepted as Standard medical treatment of the condition being treated, as determined by the Plan, or any such item requiring Federal or other governmental agency approval not granted at the time of the Orthotic Device was provided. The experimental or non-experimental nature of any Orthotic Device shall be determined by the Plan.

4.6 Repair of any Orthotic Device.

4.7 Dental appliances of any sort including, but not limited to, bridges, braces and retainers.

4.8 Mastectomy bras.

4.9 Orthotic Devices excluded from Medicare's then current medical necessity coverage criteria.

4.10 Sexual dysfunction devices, male or female.

4.11 Orthotic devices that are not obtained from a Contracted Vendor are **NOT COVERED.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Prosthetic Devices - No Copayment

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate or Agreement on the current Face Sheet of which it is currently listed as being in force. Prosthetic Devices must be obtained from a Contracted Vendor.

1. **DEFINITIONS.**

1.1 **"Contracted Vendor"** means a licensed supplier of prosthetics which has, in effect on the date of service, an agreement with the Plan to provide Standard Prosthetic Devices, as defined in Sections 1.2 and 1.3 of this Rider, to Members under the provisions of this Rider, and is so designated by the Plan.

1.2 **"Prosthetic Device"** means an externally worn appliance or apparatus which replaces a missing body part.

1.3 **"Standard"** means possessing qualities or attributes which are determined by the Plan to be: (i) in accordance with Medicare's then current medical necessity coverage criteria; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available.

2. **BENEFITS.**

2.1 **Prosthetic Devices.** Subject to the Copayments and Limitations set forth in this Rider, the Plan will pay for the purchase of Standard Prosthetic Devices, or the replacement of component parts or modification of a Standard Prosthetic Device as set forth under Section 2.2 of this Rider, when prescribed in advance by a Primary Care Physician, a Participating Provider physician on referral by a Primary Care Physician, or when approved in advance by the Plan. Standard Prosthetic Devices must be obtained from a Contracted Vendor 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.

2.2 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. **COPAYMENTS AND LIMITATIONS.**

3.1 **Copayments.** The Plan will pay 100% of the cost of purchase of a Standard Prosthetic Device subject to Section 2.1 of this Rider, and/or the replacement of component parts or modification of a Standard Prosthetic Device subject to Section 2.2 of this Rider, up to the maximum benefit limit set forth in Section 3.2 of this Rider.

3.2 **Maximum Benefit.** The maximum amount which the Plan will pay for all benefits provided under this Rider to any one Member in a calendar year is $5,000. Members must pay any remaining amounts above this maximum benefit limit.

.4. **EXCLUSIONS.** In addition to the exclusions set forth in the Certificate, the following are **NOT COVERED** under this Rider.

4.1 Deluxe equipment of any sort, or equipment which has been otherwise determined by the Plan to be non-Standard.

4.2 Disposable supplies, including, but not limited to, stump socks and gradient compression stockings.

4.3 Experimental or research equipment which is not accepted as Standard medical treatment of the condition being treated as determined by the Plan, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device was provided. The experimental or nonexperimental nature of any Prosthetic Device shall be determined by the Plan.

4.4 Repair of any Prosthetic Device.

4.5 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.

4.6 Prosthetic Devices excluded from Medicare's then current medical necessity coverage criteria.

4.7 Mastectomy Bras.

4.8 Prosthetic devices that are not obtained from a Contracted Vendor are **NOT COVERED.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Refractions

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet 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 **Refractions Benefit Maximum.** Refraction services as provided under this Rider to any Member shall be limited to one (1) examination per calendar year. 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.**

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Outpatient Prescription Drugs - With Oral Contraceptives Triple Choice Benefit

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate when this Rider is listed on the current Face Sheet of which it is currently listed as being in force.

1. **DEFINITIONS.**

1.1 **"Brand Name Drug"** means a prescription drug that is not dispensed using its generic and chemical name.

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 may be obtained from the Plan upon request.

1.3 **"Formulary Brand Name Drug"** means a Brand Name Drug which is included in the Plan's Drug Formulary.

1.4 **"Generic Drug"** means a prescription drug defined as being prescribed by its generic and chemical name heading according to the principal ingredient(s) and approved by the U.S. Food and Drug Administration (FDA).

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.

1.7 **"Non-Formulary Brand Name Drug"** 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.

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 Argus Health Systems, Inc.

1.10 **"Prescription Drug"** means any drug or medicine required by Pennsylvania or Federal law to live dispensed by a licensed pharmacist or physician, upon written or oral prescription of a physician and which is prescribed for use as an outpatient. Prescription Drug also includes oral contraceptives and diaphragms. Prescriptions requiring compounding will be covered if they contain one or more medications required by

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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 Deductible and Copayment or Coinsurance amounts as set forth on the Face Sheet.

1st Tier– This includes most Generic Drugs. No Prior Authorization is necessary for drugs in this tier.

2nd Tier – This includes certain 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. Prior Authorization may be necessary for coverage of certain drugs in this tier.

3. **BENEFIT.**

3.1 Subject to the Deductible and Copayment or Coinsurance amounts as set forth on the Face Sheet, 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 Deductible and Copayment or Coinsurance amounts as set forth on the Face Sheet, and the limitations as set forth herein, restricted drugs, 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 Face Sheet.

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 34-day period. 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 **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.

4.6 **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.

4.7 **Deductible and Copayment or Coinsurance Amounts.** Prescription Drugs covered under this Rider shall be subject to the applicable Deductible and Copayment or Coinsurance amounts as set forth on the Face Sheet.

5. **EXCLUSIONS.** The following are **NOT COVERED** under this Rider:

5.1 Drugs which are not Prescription Drugs, as defined herein.

5.2 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, diagnostic devices and supplies.

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.

5.5 Prescription or non-prescription contraceptive devices, including but not limited to condoms and implantable devices for the purpose of releasing contraceptive drugs.

5.6 Prescription Drugs prescribed for weight loss or weight management.

5.7 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.

5.8 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.

5.9 Non-Formulary Drugs, restricted drugs or drugs requiring Prior Authorization by the Plan which have been obtained prior to receiving such authorization.

5.10 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.

5.11 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.

5.12 Dietary supplements, vitamins (except prescription prenatal), fluoride supplements/rinses, anabolic steroids, blood plasma products or irrigation solutions.

5.13 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 the Certificate.

5.14 Drugs that are not Medically Necessary as determined by the Plan.

5.15 Medications for erectile dysfunction.

5.16 Replacement for lost, destroyed or stolen prescriptions.

5.17 Immunizations.

5.18 Allergy injections.

5.19 Extemporaneous dosage forms of natural estrogen or progesterone, including but not limited to oral capsules, suppositories and troches.

5.20 Prescriptions dispensed in unit doses, when bulk packaging is available.

5.21 Prescription Drugs which are not included on the Drug Formulary unless authorized in advance by the Plan.

5.22 Drugs written as Prescription Drugs which are available without a prescription in the same strength.

5.23 Prescription Drugs obtained from Non-Participating Pharmacies or Non-Participating Mail Order Pharmacies are **NOT COVERED**.

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
MANDATED RIDER

Serious Mental Illness Services

THIS RIDER provides **MANDATED BENEFITS** under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet of which it is currently listed as being in force. Services must be obtained from Participating Providers in the Plan's Designated Behavioral Health Program.

1. DEFINITIONS.

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.

2. BENEFITS.

2.1 The Mandated Benefits described in this Rider are provided to groups of fifty (50) 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 for up to thirty (30) inpatient days per calendar year

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 for up to a maximum of sixty (60) outpatient visits for either individual or group therapy (combined) per calendar year.

2.3.1 **Conversion Benefit.** One (1) covered inpatient day for the treatment of Serious Mental Illness may be converted into either: (i) two (2) outpatient visits for the treatment of Serious Mental Illness provided by a Participating Provider in the Plan's Designated Behavioral Health Program; or (ii) two (2) days of care provided through a partial hospitalization program by a Participating Provider in the Plan's Designated Behavioral Health Program.

3. COPAYMENT.

3.1 Mental health inpatient, partial hospitalization and outpatient professional services for the treatment of Serious Mental Illness are subject to the applicable Copayment amounts as set forth on the Face Sheet.

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**.

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

GEISINGER HEALTH PLAN
RIDER FOR SUPPLEMENTAL HEALTH SERVICES

Domestic Partner

THIS RIDER provides additional benefits under the terms of the Geisinger Health Plan Subscription Certificate on the current Face Sheet of which it is currently listed as being in force.

1. **DEFINITIONS.**

1.1 **"Family Dependent"** for purposes of this Rider only shall mean, an unmarried, 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 Plan 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 a way that would bar marriage; (iii) involved with the Subscriber in a committed lifetime relationship; and (iv) financially interdependent with the Subscriber for a period of not less than six (6) months.

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 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, if applicable. 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.

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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, if applicable, in writing immediately upon termination of such Domestic Partnership.

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
Health Plans
100 North Academy Avenue
Danville, PA 17822-3020