Group Subscription Certificate for Solutions

(This Subscription Certificate
also applies to Small Business)
(Rev. 5/08)

M-150-841-F Rev. 5/08

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

HEALTH MAINTENANCE ORGANIZATION
Group Subscription Certificate
Solutions

Thank you for choosing Geisinger Health Plan.

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

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

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

1. The Group Subscription Certificate (the Certificate), which identifies Covered Services and the terms and conditions of coverage awarded to all Members eligible for Group coverage;
2. Amendments to the Certificate, which inform Members of any changes to Covered Services or changes to the terms and conditions of coverage;
3. Riders to the Certificate, which identify Supplemental Health Services covered in addition to the services included in the Certificate;
4. The Schedule of Benefits to the Certificate, which sets forth, among other things, Copayment, Deductible and Coinsurance amounts expected for Covered Services, including the maximum limit charged to a Member within a calendar year and/or Benefit Period (as may be applicable);
5. Enrollment Application, which is the Subscriber's written request for enrollment;
6. The Group Master Policy, which is an agreement between the Plan and a Group for coverage arranged by the Plan to individuals eligible to receive health benefits through their employer; and
7. The Member's Identification Card.

The Plan issues these documents in accordance with the terms of a Certificate of Authority awarded by the Pennsylvania Departments of Health and Insurance, pursuant to the Pennsylvania Health Maintenance Act of 1972, as amended. Together, the Certificate and any Amendments, Riders (if any), Schedule of Benefits and the Enrollment Application to enroll in the Plan constitute the entire agreement between the Subscriber named on the Schedule of Benefits and the Plan. In addition, these documents specify the coverage extended to the Subscriber and Family Dependents in consideration of the specified premiums paid by them or on their behalf. The Certificate and all Amendments, Riders (if any), Schedule of Benefits, and the Enrollment Application to enroll in the Plan, remain in effect as long as the Group Master Policy remains in effect, or until such time that a Member's coverage may be terminated in accordance with the termination provisions outlined in the Certificate.

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

- a list of the names, business addresses and official positions of the membership of the Plan's Board of Directors;
- the procedures adopted to protect the confidentiality of medical records and other enrollee information;
- a description of the credentialing process for Health Care Providers;
- a list of the Participating Health Care Providers affiliated with hospital Participating Providers;
- whether a specifically identified drug is included or excluded from coverage;
- a description of the process by which coverage can be obtained for specific drugs prescribed by a Participating Provider, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee;
- a description of the procedures followed by the Plan to make decisions about the experimental nature of individual drugs, medical devices or treatments;
- a summary of the methods used by the Plan to reimburse for health care services; and/or
- a description of the procedures used in the Plan's quality assurance program.

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

For help and information: Members should call the Customer Service Team at the telephone number listed on the back of the Member's Identification Card weekdays between 8 a.m. and 6 p.m. to obtain approval or authorization of a health care service or other information regarding the Plan. Members may also write to Geisinger Health Plan, Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3229.

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

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

Richard J. Gilfillan, M.D.
President, Chief Executive Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

Duane E. Davis, M.D.
Vice President, Chief Medical Officer
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Exhibit 1 - Geisinger Health Plan Service Area

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

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

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

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

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

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

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

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

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

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

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

(i) Deductible;
(ii) Copayments;

(iii) amounts above a specific Benefit Limit as set forth in the Certificate and/or Schedule of Benefits;
(iv) amounts above the Lifetime Benefit Maximum as set forth on the Schedule of Benefits; and
(v) amounts for non-Covered Services.

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

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

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

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

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

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

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

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

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

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

1.19 **Deductible** means a specified dollar amount for the cost of Covered Services that must be

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

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

1.21 **Designated Transplant Facility** is a facility that has entered into an agreement with the Plan, the Plan's transplant subcontractor or national organ transplant network to provide Transplant Services when a transplant service as set forth in Section 3.27 of this Certificate is Medically Necessary for a Member. The Designated Transplant Facility is determined by the Plan or the Plan's transplant subcontractor and may or may not be located in the Service Area.

1.22 **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.

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

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

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

b) The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulation. Procedures and services provided as being related to an investigational technology, or rendered as part of a clinical trial or research protocol, including, but not limited to, services and procedures that would

otherwise be covered, and hospital admissions solely for the purpose of providing an investigational technology, research protocol or clinical trials are NOT COVERED, regardless of whether the trial is subject to FDA oversight; or

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

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

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

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

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

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

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

1.25 **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.

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

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

b) who is enrolled under this Certificate; and

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

d) a Family Dependent is also a Member as defined in Section 1.43 of this Certificate.

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

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

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

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

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

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

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

1.31 **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 any applicable law, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

1.32 **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.

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

1.33.1 **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.

1.33.2 **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.

1.33.3 **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.

1.33.4 **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.

1.33.5 **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.

1.33.6 **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.

1.33.7 **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.

1.33.8 **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.

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

1.34 **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.

1.35 **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.

1.36 **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.

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

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

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

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

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

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

1.42 **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.

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

1.44 **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.

1.45 **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.

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

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

1.48 **Pre-Existing Condition** means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present within ninety (90) days immediately prior to the effective date of coverage under a group health plan.

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

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

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

1.52 **Provider List** means a published listing (as amended from time to time) provided to Members by the Plan which sets forth the names, addresses and telephone numbers of current Participating Health Care Providers who have contracted with the Plan to provide Covered Services. The current Provider List can be found on the Plan's website (at www.thehealthplan.com) or obtained by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card.

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

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

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

1.56 **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.

1.57 **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.

1.58 **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.

1.59 **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.

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

1.61 **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.

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

SECTION 2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES

2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES.

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

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

a) an independent contractor;

b) the employee of an independent contractor; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.4.2.2 **Access to Mental Health and Substance Abuse Services.** Members may select a Provider who participates with the Plan's Behavioral Health Benefit Program to obtain Covered Services for mental health and Substance Abuse including Medically Necessary and appropriate follow-up care and diagnostic testing related to mental health or Substance Abuse care without a Referral from the Member's Primary Care Physician.

2.4.2.3 **Emergency Services**. Members may access Emergency Services as set forth in Section 3.6 of this Certificate.

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

2.5 Continuity of Care.

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

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

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

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

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

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

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

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

a) for a transitional period of up to sixty (60) days from the date the Member was notified by the Plan of the termination or pending termination of a Participating Provider, or ninety (90) days from the date the 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. If the non-Participating Provider or non-Participating Practitioner does not accept the Plan's terms and conditions, the service will not be covered by the Plan.

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

a) for a transitional period of up to ninety (90) days from the date the 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. If the non-Participating Practitioner does not accept the Plan's terms and conditions, the service will not be covered by the Plan.

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

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

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

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

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

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

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

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

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

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

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

e) Concurrent review (a 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. COVERED SERVICES

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

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

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

3.1 The following Sections set forth how a Member may obtain a Covered Service from a Participating Provider (Section 3.1.1), when services from a non-Participating Provider are Covered Services (Section 3.1.2), coverage parameters regarding the Covered Services (Sections 3.1.3.), Covered Service Location Cost Sharing (Section 3.1.4); Supplemental Health Services (Section 3.1.5) and second opinion coverage (Section 3.1.6).

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

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

a) the Member's Primary Care Physician;

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

c) the Member's mental health or Substance Abuse Participating Health Care Provider (as detailed in Sections 3.15 and 3.25 of this Certificate); and/or

d) Health Care Providers rendering Emergency Services as set forth in Section 3.6 of this Certificate.

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

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

a) Emergency Services as set forth in Section 3.6 of this Certificate;

b) Urgent Care as set forth in detail in Section 3.29 of this Certificate;

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

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

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

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

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

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

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

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

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

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

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

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

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

IDENTIFICATION OF COVERED SERVICES

Subject to all terms, conditions, definitions, exclusions and limitations in this Certificate, Members are entitled to receive the following Covered Services as set forth in this Section. All Covered Services must be Medically Necessary except for Preventive Services as set forth in Section 3.20 of this Certificate.

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

3.3 Diabetic Medical Equipment, Supplies, Prescription Drugs and Services. The following diabetic medical equipment, supplies, prescription drugs and services for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are covered when provided in accordance with an approved treatment plan established and provided through a Participating Provider. The Plan reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.

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

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

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

3.3.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered upon Referral by the Member's Primary Care Physician and provided at an approved Plan program site under the supervision of a Participating Provider with expertise in diabetes to ensure that Members with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. This shall include visits:

i) upon the diagnosis of diabetes;

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

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

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

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

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

3.6 Emergency Services. Coverage for Emergency Services provided during the period of the emergency shall include evaluation, testing, and if necessary, stabilization of the condition of the Member. Emergency Services do not require prior approval by the Plan. The use of emergency transportation and related Emergency Services provided by a licensed ambulance service shall be covered as an Emergency Service subject to the limitations in this Section. If a Member requires Emergency Services and cannot be attended to by a Participating Provider, the Plan shall cover the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Participating Provider, subject to Sections 3.6.1(d) and 3.6.2.

3.6.1 **Emergency Services Protocol.**

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

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

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

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

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

f) For the emergency treatment of sound, natural teeth please refer to Section 3.17, Oral Surgery**.** The need for these services must result from an accidental injury (not chewing or biting).

3.6.2 **Non-Participating Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Participating Provider, the Plan shall pay for the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Participating Provider. However, Emergency Services provided by non-Participating Providers will be covered as if provided by a Participating Provider only until the Plan determines the Member's condition has stabilized and the Member's care can be transferred to a Participating Provider without suffering detrimental consequences or aggravating the Member's condition.

3.6.3 **Cost Sharing.** Emergency Services are subject to the emergency room Copayment specified on the Schedule of Benefits. The Copayment will be waived if Emergency Services rendered in the emergency department of an acute care hospital result in the immediate admission of the Member to the hospital as an inpatient and the requirements for Emergency Services are satisfied.

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

3.7 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.

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

3.9 Home Health Care. Upon Prior Authorization, home health services is covered only in the event a Member is homebound except as provided in Section 3.9.4. 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 3.14.

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

3.9.1 **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.

3.9.2 **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.

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

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

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

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

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

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

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

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

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

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

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

3.11 Hospital and Ambulatory Surgical Center Services.

3.11.1 **Benefits.** Hospital benefits may be provided at a hospital Participating Provider on either an inpatient or outpatient basis or at an Ambulatory Surgical Center. Hospital services include semi-private room and board (private room when determined Medically Necessary by the Plan), general nursing care and the following additional facilities, services and supplies as prescribed through a Participating Provider (or another physician in response to an emergency): use of operating room and related

facilities; use of intensive care unit or cardiac care unit and services; radiology, laboratory, and other diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; physical therapy, occupational therapy and speech therapy, (subject to the Benefit Limits set forth in this Certificate in Section 3.21 and on the Schedule of Benefits); radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma and medical social services; cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

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

3.11.3 **Duration of Benefit**. Except for mastectomy Covered Services as set forth in Section 3.13 of this Certificate, inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the Plan and not determined to be Custodial, Convalescent or Domiciliary Care.

3.12 Implanted Devices. The following implanted devices are covered when a) provided by the Member's Primary Care Physician, a Specialist upon Referral by the Primary Care Physician or an obstetrical or gynecological Participating Health Care Provider and b) when the implanted devices are within such Participating Provider's scope of practice: implanted devices for purposes of drug delivery or contraception; cardiac assistive devices; cochlear implants and artificial joints. These devices are only covered to correct dysfunction due solely to disease or injury and not for gender reassignment.

3.12.1 **Contraceptive Implanted Devices.** Implanted devices for the purpose of contraception are covered only if the Member has one of the following two Riders:

a) Outpatient Prescription Drugs with Contraceptives or
b) Outpatient Prescription Drugs with Contraceptives – Triple Choice Benefit.

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

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

a) reconstruction of the breast on which the mastectomy was performed;
b) surgery and reconstruction of the other breast to produce a symmetrical appearance;
c) initial and subsequent prosthetic devices to replace the removed breast or portions thereof following a mastectomy will be provided; and
d) treatment of physical complications at all stages of the mastectomy including lymphedemas.

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

3.14 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery

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

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

3.15 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 with the Plan's Designated Behavioral Health Benefit Program. A Member may access mental health Covered Services in the following manner:

a) as a hospital inpatient as set forth in Section 3.19.2 (b) of this Certificate;

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

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

1) Mental Health Inpatient and Partial Hospitalization Services:
2) Non-Serious Inpatient Mental Illness Services; and/or
3) Serious Mental Illness Services.

3.16 Newborn Coverage. Newborn children are covered from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary hospital and physician services required by a newborn child of a Member when ordered or provided by Participating Providers for the treatment of medically diagnosed congenital defects and birth abnormalities (as also set forth in Section 3.22.1 of this Certificate); prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Sections 6.2.2 or 9.6 of this Certificate (as applicable).

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

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

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

3.17.3 **Temporomandibular joint (TMJ) surgery** is limited to the following:

a) correction of dislocation or complete degeneration of the temporomandibular joint (TMJ);

b) consultations to determine the need for surgery and/or

c) radiologic determinations of pathology.

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

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

3.19 Physician Services.

3.19.1 **Hospital and Ambulatory Surgical Center Physician Services.** The services listed in Section 3.11 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

a) **Hospital.** The services set forth in Section 3.11 are Covered Services when provided by physician Participating Providers (or other physicians in response to an emergency) under the orders of a physician and are provided in a hospital while the Member is admitted to the hospital as a registered bed patient or is being treated as a hospital outpatient.

b) **Ambulatory Surgical Center**. The services set forth in Section 3.11 are Covered Services when provided in an Ambulatory Surgical Center setting by physician Participating Providers (or other physicians in response to an emergency) or under the orders of a physician.

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

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

b) inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in an acute hospital **EXCEPT** if the Member is an inpatient in a psychiatric unit or in a mental hospital. Inpatient psychiatric unit and mental health services by licensed psychiatrist, clinical psychologist or other

licensed behavioral health professional are **NOT COVERED** except as may be explicitly provided under the terms of the following Riders:

i) Mental Health Inpatient and Partial Hospitalization Services;
ii) Non-Serious Inpatient Mental Illness Services; and/or
iii) Serious Mental Illness Services.

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

a) Preventive, diagnostic and treatment services listed below under **Preventive Services** in this Certificate when obtained from a Participating Provider as set forth in Section 3.1.1 of this Certificate.

b) cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer by a Participating Provider with a Referral from the Member's Primary Care Physician;

c) injectable drugs when determined by the physician to be an integral part of care rendered by the physician during a visit, limited to the amount of drug administered during the visit;

d) Medically Necessary Covered Services received from a non-Participating Provider when the Member obtains Prior Authorization because the Member's medical condition requires Covered Services that cannot be provided by a Participating Provider.

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

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

a) medical history;

b) physical examination, including basic ear screening examinations to determine the need for further hearing evaluation and basic eye screening examinations to determine the need for further vision evaluation;

c) for women, annual gynecological examination, including a pelvic examination and clinical breast exam, Chlamydia screening 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 of age*;

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

f) cholesterol screening and lipid panel.

*Benefits for mammography screening are payable only if performed by a mammography service Health Care Provider who is properly certified by the

Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

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

a) pediatric well-child visits; and

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

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

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

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

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

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

3.21 Rehabilitative Services. Upon Prior Authorization, physical, occupational and speech therapy is covered for up to forty-five (45) dates of service per calendar year. This forty-five (45) day Benefit Limit is for any combination of physical, occupational and speech therapy Covered Services received within the calendar year. The Member should note that if more than one rehabilitative service is received on a particular day, this will only count as one day towards the forty-five (45) day limit. Rehabilitative services must be obtained from a Participating Provider, and prescribed or approved in advance by the Member's Primary Care Physician or Participating Provider upon Referral.

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

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

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

3.23 Select Injectable Drugs. Subject to the terms and conditions set forth in this Certificate, the following injectable drugs are a Covered Service when provided by a Participating Provider. Such injectable drugs are subject to the Cost Sharing set forth in Section 3.23.1 and on the Schedule of Benefits.

- Amevive™ (alefacept)

- Aralast™ (purified human alpha$_1$-proteinase inhibitor)
- Aranesp™ (darbepoetin alfa)
- Avastin™ (bevacizumab)
- Boniva™ IV (ibandronate sodium)
- Cerezyme™ (imiglucerase)
- Epogen™ (epoetin alpha)
- Fabrazyme™ (agalsidase beta)
- Flolan™ (epoprostenol)
- IVIG™ (intravenous immunoglobulin)
- Kepivance™ (palifermin)
- Lucentis™ (ranibizumab)
- Lupron Depot™ (leuprolide acetate)
- Macugen™ (pegaptanib)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Orencia™ (abatacept)
- Prialt™ (ziconotide)
- Procrit™ (epoetin alpha)
- Prolastin™ (purified human alpha$_1$-proteinase inhibitor)
- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Rituxan™ (rituximab)
- Synagis™ (palivizumab)
- Tysabri™ (natalizumab)
- Visudyne™ (verteporfin)
- Vivitrol™ (naltrexone injection)
- Xolair™ (omalizumab)
- Zemaira™ (purified human alpha$_1$-proteinase inhibitor)

3.23.1 **Cost Sharing.** The Select Injectable Drugs listed above will subject the Member to the Copayment set forth on the Schedule of Benefits. The total Copayment amounts paid by the Member shall not exceed $1,200 per Member per calendar year.

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

3.25 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:

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

a) **Detoxification** means the process whereby an alcohol or drug intoxicated or dependent Member is assisted in a facility which participates in the Plan's Designated Behavioral Health Benefit Program through the period of time

necessary to eliminate by metabolic or other means, 1) the intoxicating alcohol or drugs, 2) the alcohol and drug dependency factors or 3) alcohol in combination with drugs as determined by a Participating Provider Physician, while minimizing the physiological risk to the Member.

3.25.2 **Inpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse is covered when provided on an inpatient basis in a hospital which participates in the Plan's Designated Behavioral Health Benefit Program, or in an inpatient non-hospital facility which participates in the Plan's Designated Behavioral Health Benefit Program. The following inpatient Detoxification services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

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

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

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

3.25.3.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered when provided in a facility which participates in the Plan's Designated Behavioral Health Benefit Program. The following inpatient non-hospital residential care services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies. Non-hospital residential inpatient rehabilitation services for Substance Abuse shall be limited to:

a) a Benefit Limit of thirty (30) days per calendar year; and

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

3.25.3.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered when provided by a facility which participates in the Plan's Designated Behavioral Health Benefit Program. The following outpatient facility rehabilitation services for Substance Abuse are covered when administered by an employee of the facility: physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical

laboratory testing; drugs, medicines, equipment use and supplies. Outpatient rehabilitation services for Substance Abuse shall be limited to:

a) a Benefit Limit of thirty (30) outpatient, full-service visits or equivalent partial visits each calendar year; and
b) a Lifetime Benefit Maximum of a total of one hundred-twenty (120) outpatient full service visits or equivalent partial visits.

3.25.3.3 **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 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.

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

i) **Initial Course of Treatment.** The initial course of treatment shall be considered to be the full range of Detoxification, treatment and supportive services carried out specifically to alleviate the dysfunction of the Member as set forth above in Sections 3.25.2, 3.25.3.1, 3.25.3.2 and 3.25.3.3. The initial course of treatment shall be subject to the Copayment amounts set forth on the Schedule of Benefits as well as Benefit Limits and Lifetime Benefit Maximum amounts as set forth in Sections 3.25.2.2, 3.25.3.1, 3.25.3.2 and 3.25.3.3 (expressed as admissions, days and visits).

ii) **Subsequent Course of Treatment.** Each subsequent course of treatment for a Member shall be subject to the Coinsurance amounts as set forth on the Schedule of Benefits as well as Benefit Limits and Lifetime Benefit Maximum amounts as set forth in Sections 3.25.2.2, 3.25.3.1 and 3.25.3.2 and 3.25.3.3 (expressed as admissions, days and visits).

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

3.27 Transplant Services and Authorization Requirements.

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

(i) bone marrow (allogeneic and autologous);
(ii) cornea; (does not require Prior Authorization)
(iii) heart;
(iv) heart and lung;
(v) kidney;

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

Members who have received a covered transplant under this Certificate may also receive coverage for certain services that would not otherwise be provided for under this Certificate.

3.27.2 **Prior Authorization.** All transplant surgery and transplant-related services (with the exception of corneal transplants) require Prior Authorization by the Plan. Medical criteria for any approved transplants will be applied and each potential transplant must be appropriate for the medical condition for which the transplant is proposed. Corneal transplants are covered when Medically Necessary upon Referral by the Member's Primary Care Physician and performed through a Participating Provider.

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

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

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

a) when the organ transplantation is approved by the Plan;
b) for the medical expense directly associated with the organ donation; and
c) to the extent not covered by any other program of insurance.

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

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

3.27.7 **Self-Administered Prescription Drugs.** Except as set forth in this Section 3.27.7, self-administered prescription drugs provided on an outpatient basis to Members are **NOT COVERED** unless explicitly provided under the terms of the following four Riders and listed on the current Schedule of Benefits:

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

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

a) covered only if the Member receiving Transplant Covered Services has coverage under the terms of an Outpatient Prescription Drug Rider;
b) covered only when the organ transplantation is approved by the Plan;
c) limited to the prescription drug expense directly associated with the organ donation; and
d) covered only to the extent not covered by any other program or insurance.

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

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

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 Schedule of Benefits.

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

3.28.1 **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.

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

3.29 Urgent Care. Urgent Care services received through Participating Providers in the Service Area are covered. Urgent Care services obtained from a non-Participating Provider outside of the Service Area are covered when they are provided in response to a sudden and unexpected

need for medical care while the Member is outside the Service Area which cannot be deferred until the Member's return to the Service Area.

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

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

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

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

3.31 Weight Management Program. The Plan offers a program for weight management that includes education and management on appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. This program is offered only through the Plan's designated vendors contracted for these services. The Member should contact the Customer Service Team at the telephone number on the back of the Member's Identification Card for specific information on how to access the Plan's designated participating weight management program vendors.

SECTION 4. EXCLUSIONS

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

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

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

4.3 Behavioral Services. Any treatment or care related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavioral problems and mental retardation, which extend beyond traditional medical management are **NOT COVERED**, except as provided in Sections 3.15.

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

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

4.6 Breast Surgery. Surgery for male or female breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.13 of this Certificate.

4.7 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**.

4.8 Charges Covered under certain Acts or Laws. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law are **NOT COVERED**. This exclusion applies regardless of whether the Member claims the benefit compensation.

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

4.10 Cosmetic Surgery. Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiologic function (not psychological) as determined by the Plan, is **NOT COVERED.** This exclusion does not apply to Covered Services set forth in Sections 3.13, 3.22.1 and 3.22.2.

4.11 Covered Services Obtained Outside the Service Area. Covered Services required as a result of circumstances that reasonably could have been foreseen prior to the Member's departure from the Service Area, and Covered Services which can be delayed until the Member's return to the Service Area, are **NOT COVERED.**

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

4.13 Dentistry. The Plan does **not cover general dental services,** defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia,

repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the Plan will cover expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.17.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth) or as may be explicitly provided under the terms of the following Rider: Impacted Wisdom Teeth.

4.14 **Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate at Sections 3.3 and 3.27 or as may be explicitly provided under the terms of the following four Riders:

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

4.15 **Drugs and Devices for Purposes of Contraception.** Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of the following two Riders:

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

4.16 **Drug Maintenance Programs**. Drug maintenance programs for the treatment of outpatient drug detoxification, dependency or addiction are **NOT COVERED**. This exclusion includes but is not necessarily limited to the outpatient use of the medications Suboxone™ (buprenorphine/naloxone) and Subutex™ (buprenorphine).

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

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

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

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

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

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

4.23 **Government-Sponsored Health Benefits Program.** Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are **NOT COVERED**. All

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

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

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

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

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

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

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

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

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

4.31 Maxillary or Mandibular Osteotomies. Maxillary or mandibular osteotomies are **NOT COVERED** except when performed to correct dislocation or complete degeneration of the temporomandibular joint (TMJ), as provided for in Section 3.17.3 of this Certificate.

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

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

4.33 Mental Health Inpatient Professional Services. Mental health inpatient professional Services provided by a licensed psychiatrist or clinical psychologist are **NOT COVERED** except as set forth in Section 3.19.2 (b) or as may be explicitly provided under the terms of the following three Riders:

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

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

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

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

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

4.37 Non-Participating Provider Mental Health or Substance Abuse Services. Mental health/Substance Abuse services obtained from a provider who does not participate in the Plan's Designated Behavioral Health Benefit Program are **NOT COVERED** except for Emergency Services as expressly set forth in Section 3.6 of this Certificate.

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

a) Emergency Services, as provided in Section 3.6 of this Certificate;
b) Urgent Care received outside the Service Area, as provided in Section 3.29 of this Certificate;
c) Covered Services under this Certificate in accordance with the continuity of care provisions for new and existing Members as provided in Section 2.5 of this Certificate;
d) Covered Services which are not available through a Participating Provider and for which Prior Authorization has been obtained from the Plan; or
e) If the Member has a Point of Service Rider supplementing their Certificate.

4.39 Not Medically Necessary. Covered Services which are not considered Medically Necessary by the Plan are **NOT COVERED** unless set forth as a Covered Service under Section 3.20, **Preventive Services**.

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

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

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

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

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

4.45 **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 3.3 and 3. 13 or as may be explicitly provided under the terms of the following three Riders:

a) Durable Medical Equipment;
b) Orthotic Devices; and/or
c) Prosthetic Devices.

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

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

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

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

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

4.51 **Routine Nail Trimming.** Routine nail trimming 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, grandparent, aunt, uncle, niece, nephew, or sibling or persons who ordinarily reside in the household of the Member of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.

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

4.54 **Splints for Temporomandibular Joint (TMJ) Conditions.** Splints for temporomandibular joint (TMJ) conditions are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider: Orthotic Devices.

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

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

a) provided by the Member's Primary Care Physician;
b) provided by the Member's obstetrical or gynecological Participating Health Care Provider (for services within their scope of practice);
c) authorized in advance by the Plan's Designated Behavioral Health Benefit Program;

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

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

Emergency Services provided inside or outside the Service Area do not require Prior Authorization. See Section 3.6 for the Emergency Services protocol.

4.57 Vein Sclerosing. Injection of sclerosing solution into superficial veins (commonly called spider veins) is **NOT COVERED**. Injection of sclerosing solution into varicose leg veins is **NOT COVERED** unless Medically Necessary as determined by the Plan.

4.58 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.31 of this Certificate.

SECTION 5. COMPLAINT AND GRIEVANCE PROCEDURE

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

5. COMPLAINT AND GRIEVANCE PROCEDURE.

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

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

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

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

5.1 Complaint Procedure.

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

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

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

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

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

b) the outcome of the first level review;

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

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

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

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

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

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

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

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

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

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

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

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

b) the outcome of the second level review;

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

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

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

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

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

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

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

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

Bureau of Managed Care
Pennsylvania Department of Health
Health & Welfare Building, Room 912
7th & Forster Streets
Harrisburg, PA 17120
Telephone Number: (717) 787-5193 or 1-(888) 466-2787
AT & T Relay Service: 1-(800) 654-5984 (TT)
Fax Number: (717) 705-0947

OR the Pennsylvania Department of Insurance:

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

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

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

5.2 Grievance Procedure-Medical Necessity and Appropriateness of Care Determinations.

5.2.1 **First Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, may file a **written** request (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) to have the Plan review the denial of payment for a health care

service based on Medical Necessity and appropriateness of care, including approval by the Plan of an alternative Covered Service or approval of a Covered Service for a lesser scope or duration than requested. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of an adverse benefit determination and should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 North Academy Avenue, Danville, PA 17822. The Plan shall notify the Member and Health Care Provider who filed the Grievance with the Member's written consent, of its receipt in writing including a detailed explanation of the Grievance process.

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

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

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

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

b) the outcome of the First Level Grievance Review;

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

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

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

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

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

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

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

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

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

5.2.2.1 **Second Level Internal Review Committee**. The Second Level Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination or of the First Level Internal Review Committee reviewers. The Second Level Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the Member or a Health Care Provider with the Member's written consent, the Plan shall provide the Member or the Health Care Provider who filed the Grievance with the Member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the Grievance. The Member and the Health Care Provider who filed a Grievance have the right to appear before the Second Level Internal Review Committee. The Plan and the Member have the right to be represented by an attorney or other individual before the Second Level Internal Review Committee. The Plan shall provide at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Second Level Grievance Review meeting to the Member and the Health Care Provider who filed the Grievance with the Member's written consent.

5.2.2.2 **Time Frame for Decision.** The Second Level Grievance Review for Pre-Service and Post-Service appeals shall be completed and a decision rendered

with written notification of the Committee's decision to the Member no later than thirty (30) calendar days from receipt of the Second Level Grievance and within five (5) business days of the Committee's decision.

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

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

b) the outcome of the Second Level Grievance Review;

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

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

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

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

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

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

i) an explanation of how to request an External Grievance Appeal Review by an independent Certified Review Entity (CRE) assigned by the Department of Health and notification that the Member or filing Health Care Provider has the right to provide additional material including, but not limited to, written comments, documents, records or other information to be considered as part of the External Grievance Appeal Review, including a statement that the Member and Member Representative do not bear any costs of the independent External Grievance Appeal Review; and

j) the time frame of fifteen (15) days from receipt of the written notification of the decision of the Second Level Grievance Review for the Member or the filing Health Care Provider to file a request for an External Grievance Appeal Review.

5.2.3 **External Grievance Appeal Review.** The Member or the Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the Second Level Internal Review Committee, may appeal to the Department of Health by filing a request, **in writing**, to the Plan **within fifteen (15) calendar days** of receipt of the notice of denial.

5.2.3.1 **Procedure.** The Plan shall contact the Member or the Health Care Provider who filed the External Grievance Appeal and the Department of Health within five (5) business days of the filing of the External Grievance Appeal. The Department will assign a CRE within two (2) business days of receiving the request. Within fifteen (15) calendar days of the receipt of the request for an External Grievance Appeal, the Plan shall forward copies of all written documentation regarding the Member's Grievance to the CRE assigned to perform the External Grievance Appeal. The Plan shall notify the Member and the filing Health Care Provider of the list of documents being forwarded to the CRE for the external review within fifteen (15) calendar days of receipt of the request. The Member or the filing Health Care Provider may supply additional information to the CRE, with copies to the Plan, for consideration in the External Grievance Appeal Review within fifteen (15) calendar days of filing the request with the Plan.

5.2.3.2 **Time Frame for Decision**. The External Grievance Appeal Review shall be completed and a decision rendered within sixty (60) calendar days of the request and a written response shall be provided to the Member and the filing Health Care Provider, the Plan and the Department. Notification to the Member and filing Health Care Provider shall include the basis for the decision and information that the Member or the filing Health Care Provider will have sixty (60) calendar days from receipt of the decision of the External Grievance Appeal Review to appeal to a court of competent jurisdiction.

5.3 Expedited Grievance Review Procedure. Should the Member's life, health or ability to regain maximum function be in jeopardy by delay caused by the Plan's review procedure, the Member or a Health Care Provider with the Member's written consent, may request an Expedited Grievance Review (orally or in writing). The Plan will perform an Expedited Grievance/Urgent Care Appeal Review when:

1) upon review by the Plan, the Member's request meets medical criteria to initiate the Expedited Grievance Review process; or
2) it is the Health Care Provider's opinion that the Member is subject to severe pain that cannot be managed without the care or treatment being requested; or
3) the Member provides the Plan with a certification, in writing, from the Member's physician stating that the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Pre-Service Grievance Process of thirty (30) days. The certification must include a clinical rationale and facts to support the physician's opinion; or
4) requests concerning admissions, continued stay or other health care service for a Member who has received emergency services but has not been discharged from a facility.

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

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

care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review.

5.4 Expedited External Grievance Review Procedure. The Member or the Health Care Provider with the Member's written consent, who is dissatisfied with the decision of the Plan's Expedited Grievance Review may appeal to the Department of Health by filing a request orally or in writing to the Plan within two (2) business days of receipt of the Expedited Grievance Review decision. The Plan shall submit to the Department of Health the Member's request for an Expedited External Grievance Review within twenty-four (24) hours of receipt. The Department, within one (1) business day of receiving the request for an Expedited External Grievance Review, will assign a CRE. The Plan shall be responsible to transfer documents regarding the review to the CRE for receipt on the next business day. The CRE shall have two (2) business days to review and render a decision. The assigned CRE is required to review and issue a written decision to the Member and the Member's Representative, the Health Care Provider, if the Health Care Provider filed the Expedited External Grievance with the Member's consent, the Plan and the Department of Health, within two (2) business days. The Expedited External Grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the Expedited External Grievance Review decision.

SECTION 6. ELIGIBILITY

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

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

a) a full-time resident of the Service Area or work within the Service Area and live within twenty (20) minutes or twenty (20) miles of a Participating Primary Care Physician; and

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

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

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

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

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

a) the spouse of a Subscriber; or

b) an unmarried dependent child whose age is less than the Maximum Age for dependent children as stated on the Schedule of Benefits.

A dependent child is defined as:

a) a natural child,

b) an adopted child or child placed for adoption,

c) a natural child or an adopted child of the Subscriber or the Subscriber's spouse, for whom the Subscriber is obligated to provide health care coverage through a court order, or qualified medical support order, or

d) any other child of whom the Subscriber or the Subscriber's spouse is the custodial parent, Legal Guardian or Legal Custodian. The Plan may periodically require documentary proof of such dependency.

A Family Dependent must reside in the Service Area or reside with the eligible Subscriber, unless the Family Dependent is covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania.

Eligibility shall cease for a dependent child on the last day of the month in which the dependent child reaches the Maximum Age, becomes married or obtains full-time

employment (except for disabled dependent children and students). Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage.

6.2.1 **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 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 Schedule of Benefits gives two (2) Maximum Ages for dependent children: one (1) for dependent children who are full-time students and one (1) for all other dependent children. The full-time student Maximum Age shall apply to an individual who is either a high school student or enrolled in an approved institution of higher learning pursing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study. The Plan may periodically require documentary proof of enrollment as a student upon reaching the Maximum Age for dependent children set forth on the Schedule of Benefits, or upon the date on which the Plan is first notified of such enrollment.

6.2.6.1 **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 (30) or more consecutive days; or (ii) members of the Pennsylvania National Guard ordered to active state duty, including duty related to the Emergency Management Assistance Compact, for a period of thirty (30) or more consecutive days, the following shall apply:

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

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

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

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

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

6.2.7 **Noncustodial Children.** A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order. The Subscriber must make written application for membership of such child. The Plan will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty (30) days of receipt by the Plan of said official court order. The Subscriber shall notify the Plan of the name and address of the custodial parent in order to allow the Plan to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania. The Plan may not disenroll or eliminate coverage of any child unless the Plan is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

6.3 Continued Eligibility During Military Service. If a Subscriber is called to Active Military Duty (for the purpose of this Section only, Active Military Duty is defined as voluntary or involuntary duty in a uniformed service under competent authority), coverage will continue under the Plan for the first thirty (30) days of the Active Military Duty. After the expiration of the first thirty (30) days, the Subscriber will be given the option of continuing health care coverage at their own expense through a COBRA offering for themselves and their eligible Family Dependents. This COBRA offering will be at the same rate paid by the employer for the Subscriber's and the Subscriber's eligible Family Dependents' coverage. The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.22 of this Certificate.

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

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

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

b) have properly elected to receive COBRA coverage.

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

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

ii) the Subscriber on behalf of himself and/or any Family Dependent(s).

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

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

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

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

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

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

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

a) newly married spouses, newborns, adopted children 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.

6.6 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the Plan by submitting a completed Enrollment Application on forms provided by the Plan (or provided by the Group if approved by the Plan). No eligible person will be refused enrollment within thirty-one (31) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a special enrollment period. No evidence of insurability shall be required.

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

6.7.1 **Special Enrollment Period-Loss of Eligibility Status.** An individual who loses eligibility for enrollment under another group health benefits program may enroll in this Plan at a time other than an Open Enrollment Period, if the Plan receives satisfactory evidence that:

a) the individual was actually enrolled for benefits under the other program at the time he first became eligible for this Plan;

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

c) the individual was enrolled in the other program during the most recent Open Enrollment Period, if eligible for this Plan at that time;

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

i) termination of employment;
ii) reduction in the number of hours of employment;
iii) termination of the other program's coverage;
iv) termination of contributions toward the premium made by the Group;
v) death of a spouse, divorce, or legal separation;
vi) expiration of the COBRA continuation of coverage 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:

6.8 Pre-Existing Condition Exclusion. Coverage for Pre-Existing Conditions shall begin after the Member has been covered under this Plan for twelve (12) months. This exclusion applies to all services, with the exception of those set forth in this Certificate. The Pre-Existing Condition exclusion shall begin from the date of enrollment under the Certificate and credit shall be given for the time the Member had Creditable Coverage as set forth in Section 6.8.2. To the extent that this Certificate replaces another group contract, the Plan shall only apply a pre-existing condition exclusion if excluded by the other group policy.

6.8.1 **Exceptions to Pre-Existing Condition Exclusion.** The Pre-Existing Condition Exclusion set forth in this Section is not applicable to:

a) a newborn child;
b) an adopted child or a child pending placement (under 18 years of age);
c) a newborn child born to a Family Dependent;
d) a new spouse;
e) services provided by the Member's Primary Care Physician;
f) Emergency Services;
g) pregnancy;
h) genetic information (in the absence of diagnosed condition); or
i) to Members for whom this Certificate replaces prior group coverage that did not contain the pre-existing condition exclusion.

6.8.2 **Creditable Coverage.** The Pre-Existing Condition Exclusion period may be reduced in the event a Member has had insurance coverage through another health insurer.

The Member may have received a certificate with information regarding prior Creditable Coverage from the Member's previous employer, insurer or other health benefits provider. The certificate of Creditable Coverage is extremely useful for demonstrating Creditable Coverage. If the Member does not have such a certificate, the Member has the right to request one (within twenty-four (24) months after coverage ceases). At the Member's request, the Plan will assist the Member in obtaining the certificate of Creditable Coverage. The Member can request assistance from the Plan by calling the Customer Service Team at the telephone number indicated on the back of the Member Identification Card.

6.9 Hospitalization on the Effective Date. A Member who is hospitalized prior to the effective date of coverage hereunder is covered for Covered Services (s) as of the effective date of enrollment in the Plan unless:

a) covered under a continuation of benefits provision through another carrier; or

b) they are an admitted patient in a non Participating Provider facility who does not accept the Plan's terms and/or benefits.

Expenses incurred prior to the effective date of enrollment in the Plan are **NOT COVERED**.

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

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

7. PAYMENT PROVISIONS.

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

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

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

7.4 Grace Period. If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within thirty (30) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 9.3.1 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 9.6 of this Certificate. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependents during the grace period.

SECTION 8. LIMITATIONS

8. LIMITATIONS.

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

8.2 Coordination of Benefits.

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

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

i) group-type health benefits coverage, whether insured or uninsured, which is not available to the general public;

ii) coverage under a governmental health benefits program or a program required by law. This does not include a state program under Medicaid (Title XIX, Grants to States for Medical Assistance programs of the United States Social Security Act, as amended from time to time). It also does not include any health benefits program that by law the benefits exceed those of any private insurance program or any other non-governmental program.

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

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

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

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

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

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

d) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one (1) or more Programs covering the Member for whom the claim is made.

The term Allowable Expense does not include coverage for items **NOT COVERED** under this Certificate. When This Plan provides Covered Services, the reasonable cash value of each service is the Allowable Expense and is considered a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the Member's stay in a private hospital room is Medically Necessary.

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

8.2.2 **Applicability.**

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

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

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

8.2.3 **Order of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In such event, the benefits of This Plan will be reduced so that they and the benefits payable under the other Programs do not total more than the Allowable Expenses. When the benefits of This Plan are reduced as described herein, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

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

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

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

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

b) insurance companies; or

c) other organizations.

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

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

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

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

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

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

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

e) This Plan is **secondary** to Medicare when the Subscriber is under the age of sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability, is an Active Employee (defined by Medicare regulations) and works for an employer with less than one hundred (100) employees.

f) If the Subscriber has End Stage Renal Disease (ESRD) the Plan will be primary for the first thirty (30) months of the Subscriber's entitlement to Medicare (as defined by Medicare regulations). After the first thirty (30) months, Medicare will become the primary coverage. However, if the Plan is currently providing benefits as the secondary provider when the Subscriber becomes entitled to ESRD Medicare benefits, the Plan will remain the secondary provider. The same conditions apply as indicated above in regard to ESRD if the Subscriber has COBRA coverage under the Plan.

The Subscriber is strongly encouraged to refer to Medicare regulations in regard to the specific requirements for Medicare entitlement.

8.2.9.2 **Double Coverage.** The benefits provided under this Certificate are not designed to duplicate any benefits for which a Member may be eligible under the terms of Medicare, any government-sponsored health benefits program or any applicable Worker's Compensation Law. Benefits hereunder will be reduced to the extent that benefits are eligible for payment regardless of whether the Member has enrolled for participation under Medicare or any government-sponsored health benefits program. Benefits also will be reduced to the extent that benefits are received by the Member under any form of Worker's Compensation coverage. In the event a Member fails to receive benefits for which he is otherwise eligible under the terms of Medicare, any government-sponsored health benefits program or Worker's Compensation because of the failure of the Member to apply for or maintain Medicare or any government-sponsored health benefits program coverage, or to submit required claim documentation or other required documentation, benefits under this Certificate will be reduced by the amount of benefits which the Member would otherwise have received under Medicare, any government-sponsored health benefits program or Worker's Compensation. **If the Member enters into an agreement to settle the Worker's Compensation claim, any future expenses for Covered Services rendered for the injury compensated by the settlement are NOT COVERED.**

8.3 Subrogation. The Plan has the right of subrogation to the extent permitted by the law against third parties that are legally liable for the expenses paid by the Plan under this Certificate. The Member shall do nothing to prejudice the subrogation rights of the Plan. The Plan may recover benefits amounts paid under this Certificate under the right of subrogation to the extent permitted by law.

SECTION 9. TERM AND TERMINATION

9. TERM AND TERMINATION.

9.1 Term. The effective date of this Certificate is stated on the Schedule of Benefits. The initial term of this Certificate commences on such effective date and continues until the renewal date of the Group Master Policy. This Certificate shall automatically be renewed thereafter from year-to-year, unless sooner terminated as set forth below.

9.2 Termination by the Group. The Group may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Group shall result in the individual rights to benefits and Covered Services awarded under this Certificate ceasing on the effective date of termination, except as set forth in Section 9.6 Continuation of Benefits.

9.3 Termination by the Plan. The Plan may terminate this Certificate for the following reasons:

9.3.1 **Failure to Pay.**

9.3.1.1 **By the Subscriber.** In the event any Subscriber fails to pay any amount due the Plan, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the Plan to the Group and to the Subscriber. A Member whose coverage is terminated under this Section for failure to pay may not reapply for a period of eighteen (18) months following such termination.

9.3.1.2 **By the Group.** In the event the Group fails to pay any amount due the Plan, for the benefit of the Subscriber or any Family Dependents, coverage shall terminate for the Subscriber and all Family Dependents upon fifteen (15) days written notice by the Plan to the Group and to the Subscriber. A Member whose coverage is terminated due to the Group's failure to pay pursuant to this Section and who continues to reside in the Service Area may be eligible for conversion to individual, direct payment coverage without evidence of insurability, provided that application is made within thirty-one (31) days of the date of notification of termination and subject to payment of premiums as billed within thirty-one (31) days of the date such bill is issued. If the Member fails to apply with the Plan for conversion coverage within thirty-one (31) days of the date of the termination notification date, the Member upon future application to the Plan will need to provide evidence of insurability as part of the process.

9.3.2 **Fraud or Material Misrepresentation.**

9.3.2.1 **By the Group.** In the event the Group makes an intentional misrepresentation for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.2.2 **By the Member.** If it is proven that the Member attempted or committed fraud under this Certificate to obtain benefits or payment or if the Member makes an intentional misrepresentation of material fact in the application

for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber and the Group. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

A Member whose coverage is terminated under this Section for fraud or material misrepresentation may not apply to the Plan for health coverage for a period of thirty six (36) months following such termination.

9.3.3 **Violation of the material terms of the contract.**

9.3.4 **Failure to Continue to Meet the Group Eligibility Requirements.** If a Member ceases to meet the Group eligibility requirements, coverage shall terminate subject to fifteen (15) days written notice by the Plan to the Group and the Subscriber.

9.3.5 **Termination of Group Master Policy.** The Plan may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Plan means that individual rights to benefits and Covered Services awarded under this Certificate cease on the effective date of termination. If a Member whose coverage was terminated pursuant to this Section has succeeding or alternate carrier health service coverage, they are not eligible for conversion to individual, direct payment coverage. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 9.6 of this Certificate.

9.3.6 **Failure to Establish Physician-Patient Relationship.** If a Primary Care Physician is unable to establish or maintain a satisfactory physician-patient relationship with a Member, coverage of the Member (including all enrolled Family Dependents if the Member in question is the Subscriber) may be terminated, subject to the following: (i) the Plan has in good faith provided the Member with an opportunity to select another Primary Care Physician; (ii) the Member has repeatedly refused to follow the plan of treatment ordered by a Primary Care Physician or other physician providing services under the terms of this Certificate; and (iii) the Member is notified in writing at least thirty (30) days in advance that the Plan considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination subject to the Plan's Complaint procedure. Such termination shall be subject to thirty-one (31) days written notice by the Plan to the Group and the Subscriber and the decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.7 **Residence Out of the Service Area.** To be eligible to enroll, and to continue enrollment in the Plan, a Member must be a full-time resident of the Service Area, or reside with a Subscriber who works within the Service Area and lives within twenty (20) miles or twenty (20) minutes of a Participating Primary Care Physician. Except for students or a Family Dependent covered by a court order or qualified medical support order pursuant to the laws of the Commonwealth of Pennsylvania, any Member who:

a) is absent from the Service Area for more than ninety (90) consecutive days; or

b) works within the Service Area but no longer lives within twenty (20) miles or twenty (20) minutes of a Participating Primary Care Physician

shall no longer be considered a permanent resident of the Service Area and coverage shall be terminated upon fifteen (15) days written notice by the Plan to the Group and the Subscriber.

9.3.8 **Subscriber's Death.** In the event of the death of a Subscriber, coverage shall terminate for his enrolled Family Dependents on the last day of the period for which payments have been made by, or on behalf of such Subscriber, subject to the conversion privilege set forth below. Surviving Family Dependents may also be eligible to continue Group coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 9.6.

9.3.9 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage with respect to the child subject to fifteen (15) days written notice by the Plan to the Group and the Subscriber. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.10 **Disruptive Behavior.** The Plan may terminate a Member's coverage for cause if the Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his continuing membership in the Plan seriously impairs the Plan's ability to provide Covered Services to either that Member or to other Members. Termination will occur after the Plan has made a reasonable effort to resolve the problem presented by the Member, including encouraging the Member to utilize Plan's internal Complaint procedure as set forth in Section 5 of this Certificate.

9.3.11 **Conversion Privileges.** If a Member's coverage terminates for any reason other than non-payment of a required contribution and the Member has been continuously insured under the Certificate for at least three (3) months immediately prior to termination, the Member shall be eligible for individual conversion coverage (referred to as "Conversion Coverage").

A Member is not entitled to Conversion Coverage if other similar group coverage will replace this Certificate within thirty-one (31) days, or if coverage terminated under the Certificate because the Member failed to pay required premium contributions. Members who are eligible to continue Group coverage under the provisions of COBRA (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.

9.4 Reinstatement.

9.4.1 The Plan shall automatically reinstate a Member whose coverage has been terminated due to a clerical error on behalf of the Plan, when the Plan becomes aware of any clerical error. Automatic reinstatement by the Plan under this Section will not

require reapplication or submission of evidence of insurability. Premiums shall be payable from the effective date of reinstatement.

9.4.2 At the Plan's sole discretion, the Plan may reinstate a Member whose coverage has been terminated:

a) for loss of eligibility, if the Member recaptures eligibility status and continues to satisfy the eligibility requirements; or

b) at the Subscriber's request, if the Subscriber or the Group notifies the Plan within thirty-one (31) days of the date of the initial request to terminate that termination is no longer desired.

9.5 Refunds. When a Member's coverage is terminated, any periodic payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded or credited to the Group. Neither the Plan nor Participating Providers shall have any further liability under this Certificate.

9.6 Continuation of Benefits. If a Member is an inpatient in a hospital or skilled nursing facility on the effective date of termination, the benefits for inpatient Covered Services shall be provided:

1. until the inpatient stay ends; or
2. until 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
   up to the end of the Benefit Period;

whichever occurs first.

In the event coverage terminates because of active employment termination, the Covered Services will be provided for twelve (12) months during total disability with respect to the sickness or injury which caused the disability unless coverage is afforded for total disability under another group plan.

9.7 Health Status. Members enrolled under this Certificate will not have coverage terminated because of health status or requirements for health services.

SECTION 10. GENERAL PROVISIONS

10. GENERAL PROVISIONS.

10.1 Disclaimer of Liability. It is expressly understood that the Plan (as a corporation or otherwise) does not furnish any health service benefits. The Plan contracts with professional providers of care for the Covered Services received by Members under this Certificate. The Plan's obligation is limited to furnishing Covered Services through contracts with such providers of care. The Plan (as a corporation or otherwise) is not, in any event, liable for any act or omission of the professional personnel of any medical group, hospital, or other provider of services.

10.2 Designation of an Authorized Representative. Members have the right to designate an authorized representative who, in addition to the Member receiving services, will receive Explanation of Benefits forms from the Plan. If a Member wishes to designate an authorized representative, they must complete and sign an authorized representative form. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member Identification Card.

10.3 Claims and Reimbursement.

10.3.1 **Claims.** The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to a Member as follows:

a.) **Participating Provider Claims.** The timely filing of claims is the responsibility of the Participating Provider, and the Member will have no payment responsibility for such claim which is not filed on a timely basis by the Participating Provider.

b.) **Non-Participating Provider Claims.** Members are required to file a claim for all services rendered by a non-Participating Provider. No payment will be made for any claims filed by a Member for services rendered by a non-Participating Provider unless the Member gives written notice of such claim to the Plan within one (1) year of the date of service.

To file a claim, the Member should call the Plan at the telephone number listed on the Member Identification Card to obtain a claim form. Section A of the claim form must be signed by the Member before the Plan will issue payment to a provider or reimburse the Member for services received under this Certificate. The Member must complete a claim form for services rendered by a non-Participating Provider and submit it, together with an itemized bill, to the following address:

Geisinger Health Plan
P.O. Box 8200
Danville, PA 17821-8200

If a claim form is not received by the Member within fifteen (15) days of request to the Plan, the Member may provide an itemized bill from the provider containing the following information, in writing, in lieu of the claim form:

1.) Full name of Member for whom the services were rendered.

2.) Date(s) of service.

3.) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
   a. Procedure/Service codes (and Modifiers)
   b. Diagnosis codes
   c. Location code

4.) Charges for each service.

5.) Servicing provider/facility and address. If available, telephone number and provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Health Plan
P.O. Box 8200
Danville, PA 17821-8200

Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof of loss is otherwise required.

10.3.2 **Reimbursement.** In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, the Plan will reimburse the Member by check immediately upon receipt of the written proof of claim set forth under Section 10.3.1 of this Certificate. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the Plan as soon as possible, but in no event later than one year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

10.4 Amendments. The provisions of this Certificate cannot be altered or changed by any representative or agent of the Plan, other than by a written Amendment or Rider signed by the President or other authorized officer of the Plan.

10.5 Authorization to Disclose Confidential Information. Subject to the Medical Records confidentiality provisions, the Plan is entitled to receive from any provider of Covered Services to any Member, information reasonably necessary in connection with the administration of this Certificate.

10.6 Modifications. Through the Group Master Policy, the Group makes coverage under this Certificate available to persons who are eligible. However, the Group Master Policy and this Certificate shall be subject to amendment, modification or termination in accordance with any provision thereof or hereof without the consent or concurrence of or notice to the Members, except as provided for herein. By electing coverage pursuant to this Certificate or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, amendments and provisions thereof and hereof. Disclosure of information regarding a change to benefits shall be provided to Members within thirty (30) days of the effective date of the change.

10.7 Enrollment Applications and Statements. Members or applicants for membership shall complete and submit to the Plan such Enrollment Applications, or other forms or statements as the Plan may reasonably request. Members and applicants for membership represent that all information contained in such Enrollment Applications, forms or statements submitted to the Plan prior to enrollment under this Certificate or the administration hereof shall be true, correct and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct and complete.

10.8 Policies and Procedures. The Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Certificate.

10.9 Computation of Time. Unless otherwise specifically stated, all references in this Certificate to "day" shall mean calendar day. All references to "effective date" shall mean 12:01 a.m. of such calendar date determined on the basis of the location of the Plan's address.

10.10 Clerical Error. Clerical error, whether of the Group or the Plan, in keeping any record pertaining to the coverage under this Certificate will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10.11 Gender. All pronouns used herein shall include both the masculine and the feminine gender, as the context requires.

10.12 Notices. Any notice under this Certificate may be given by United States Mail, first class, postage prepaid, addressed as follows:

Geisinger Health Plan
M.C. 3220
100 North Academy Avenue
Danville, PA 17822
Attention: Administration

Claims and requests for reimbursement should be sent to the attention of the "Claims Department." Notice to a Member will be sent to the Member's last address known to the Plan.

10.13 Substitution of Non-Covered Services. Other provisions of this Certificate notwithstanding, the Plan reserves the right to provide any service, supply, equipment or benefit which is otherwise **NOT COVERED**, or which is limited or excluded, when, in the sole judgment of the Plan, provision of such service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equivalent benefits available under this Certificate. Any such substitution shall be subject to such quality assurance standards as the Pennsylvania Department of Health may establish.

10.14 Certificate of Creditable Coverage. Upon termination of a Member's coverage, the Plan will automatically issue a Certificate of Creditable Coverage. The Certificate of Creditable Coverage indicates the length of time the Member had continuous health coverage under the Plan. In the event additional Certificates of Creditable Coverage are required, the Member has the right to request them within twenty-four (24) months after coverage terminates or at any time while enrolled in the Plan. A Member may request a Certificate of Creditable Coverage by contacting the Customer Service Team at the telephone number on the back of the Member's Identification Card.

10.15 Discretionary Authority. The Plan has the full discretionary authority to make benefit and eligibility determinations and adjudicate claims under the Group's health benefit plan.

10.16 Compliance with the Law; Amendment. Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Certificate, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Certificate for any one (1) or more eligible Members enrolled under this Plan, and each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose, provided that the changes described in such Amendment are made on a uniform basis consistent with the provisions of HIPAA.

10.17 Governing Law. This Certificate is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Certificate shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

EXHIBIT 1
GEISINGER HEALTH PLAN
SERVICE AREA

SERVICE AREA shall mean the following counties located in Pennsylvania: Adams, Bedford, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Elk, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York.

(In Bedford, Cumberland, Elk and Perry 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