GEISINGER ALL-ACCESS EXTRA HMO

Group Subscription Certificate

M-152-077-F Rev. 4/23

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

HEALTH MAINTENANCE ORGANIZATION
Group Subscription Certificate

Thank you for choosing a Geisinger All-Access Extra HMO product.

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

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

1. The Group Subscription Certificate (the Certificate), which identifies 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, the 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 Enrollment Letter.

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

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

- a list of the names, business addresses and official positions of the membership of the Plan's Board of Directors;
- the procedures adopted to protect the confidentiality of medical records and other enrollee information;
- a description of the credentialing process for Health Care Providers;
- a list of the Participating Health Care Providers affiliated with hospital Participating Providers;
- whether a specifically identified drug is included or excluded from coverage;
- a description of the process by which 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 located on the back of the Member's Identification Card weekdays between 8 a.m. and 6 p.m. to obtain approval or authorization of a health care service or other information regarding the Plan. Members may also write to us at 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, we will provide an appropriate interpreter to translate for the Customer Service Team representative and the Member.

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

Kurt J. Wrobel
President
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

John B. Bulger, DO, MBA
Chief Medical Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3220

Discrimination is against the law

Geisinger Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Geisinger Health Plan at 800-447-4000 or TTY: 711.

If you believe that Geisinger Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225

GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف أصم وأبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺមានសេវាសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

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TABLE OF CONTENTS

1. **GENERAL DEFINITIONS** 5
This Section lists definitions of words and phrases used in this Group Subscription Certificate.

2. **PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES** 13
This Section explains how to choose a Primary Care Physician, how the Primary Care Physician initiates a Standing Referral and how the Plan gives Prior Authorization for Covered Services.

3. **COVERED SERVICES** 18
This Section describes those Covered Services provided by this Certificate. This Section also describes what to do in an emergency or how to arrange for care outside the Service Area.

4. **EXCLUSIONS** 44
*This Section describes those services that are **NOT COVERED** by the Plan.*

5. **COMPLAINT AND GRIEVANCE PROCEDURE** 51
This Section describes a Member's rights if he or she believes they have not received the benefits or services to which they are entitled.

6. **ELIGIBILITY** 60
This Section describes the requirements each Member and their dependents must meet in order to be covered by this Plan.

7. **PAYMENT PROVISIONS** 68
This Section describes the method of payment for this Plan.

8. **LIMITATIONS** 69
This Section describes the conditions that may restrict the benefits of this Plan.

9. **TERM AND TERMINATION** 76
This Section describes the conditions under which the Plan or a Member's employer may discontinue coverage.

10. **GENERAL PROVISIONS** 80

Exhibit 1 - Geisinger Health Plan Service Area

Exhibit 2 - Preventive Services List

SECTION 1. DEFINITIONS

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

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

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

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

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

1.5 Benefit Period means the period of time this Certificate is in effect as indicated on the Schedule of Benefits. A Member's Benefit Period shall begin on the Effective Date as noted 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 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).

1.8 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.

1.9 Commissioner means the Insurance Commissioner of the Commonwealth of Pennsylvania.

1.10 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.

1.11 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.

1.12 Cost Sharing means the Copayment, Coinsurance, Deductible 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.

1.13 **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 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.

1.14 **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.

1.15 **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.

1.16 **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 3.37 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.

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

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

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

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

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

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

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

1.21 **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, III, or IV 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.

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

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

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

b) who is enrolled under this Certificate;

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

d) a Family Dependent is also a Member as defined in Section 1.42 of this Certificate.

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

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

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

e) rescission.

1.26 **Group** means the employer, 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.

1.27 **Group Master Policy** means the agreement between the Plan and the Group providing for the administration of enrollment, payment of premiums, and other matters pertaining to the provision of 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.

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

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

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

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

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

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

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

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

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

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

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

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

a) establishing the Plan of Care;

b) periodically reviewing and updating the Plan of Care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.34 **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.

1.35 **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.

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

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

(i) amounts above a specific Benefit Limit as set forth in the Certificate and/or Schedule of Benefits; and
(ii) 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 Maximum Out-of-Pocket has been reached. The Maximum Out-of-Pocket applies to each Member or Family Unit subject to any family Maximum Out-of-Pocket set forth on the Schedule of Benefits.

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

1.39 **Medical Necessity or Medically Necessary** means Covered Services rendered by a Health Care Provider that the 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.

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

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

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

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

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

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

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

1.45 **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 2.7.2 (Termination of Participating Provider or Participating Practitioner Without Cause) of this Certificate.

The Plan contracts with a national provider network of professionals and facilities. Participating Providers within such national preferred provider organization shall not be Participating Health Care Providers or Participating Providers unless otherwise provided by the Plan. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Participating Providers.

1.48 **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 designee) who has an agreement with the Plan to coordinate and provide initial and basic care to Members and who may initiate standing Referrals for Specialist care.

1.49 **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.

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

1.51 ***ProvenHealth Navigator*® Sites** are those sites designated by the Plan where a Member can receive PCP care from a *ProvenHealth Navigator*® Provider.

1.52 ***ProvenHealth Navigator*® Providers** are those PCPs and/or their Plan-recognized physician extenders who provide primary care Covered Services at a *ProvenHealth Navigator*® Site.

1.53 **Provider** shall mean Health Care Provider.

1.54 **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.GeisingerHealthPlan.com). A Member may also request a copy of the most current Provider List by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card or by writing to the Customer Service Team at the address listed on page 2 of this Certificate.

1.55 **Referral** is the means 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. Under this Certificate, a Member may access Covered Services without a Referral.

1.56 **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.

1.57 **Schedule of Benefits** is a summary of coverage for a Member that identifies the Maximum Age for dependent coverage together with the applicable Copayments or Coinsurance, 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.

1.58 **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 and Pennsylvania Department of Insurance.

1.59 **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.

1.60 **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.

1.61 **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.

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

1.63 **Telehealth** means remote clinical services and remote non-clinical services.

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

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

SECTION 2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES

2. **PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES**.

2.1 ***ProvenHealth Navigator®* care.** A *ProvenHealth Navigator®* site is a medical practice site designated by the Plan as a site where the Member can receive primary care Covered Services for a lower PCP office visit Copayment (refer the Schedule of Benefits for specific Cost Sharing). A *ProvenHealth Navigator®* site has Plan nurses available who work closely with the PCPs at the site to provide services such as:

- same-day appointments for urgent care;
- on-site health coaching;
- assistance managing all the Member's care if the Member has a complex medical condition;
- preventive care such as flu shots or other immunizations;
- education about managing diabetes, heart disease and other medical conditions; and
- assistance for Members transitioning from a hospital to their home.

ProvenHealth Navigator® sites can provide both adult PCP and pediatric PCP care. *ProvenHealth Navigator®* sites provide only PCP Covered Services. A Member can go to any *ProvenHealth Navigator®* site to receive Covered Services but it is recommended that the Member consider using the same site to build a relationship with the PCPs at that site and for continuity of medical condition management and other longer-term services. The Member can get a list of current *ProvenHealth Navigator®* sites by calling the Customer Service Team at the number on the back of the Member Identification Card or by going to the Plan's website at www.GeisingerHealthPlan.com.

2.2 **Non-*ProvenHealth Navigator®* care**. A Member can receive Covered Services from any PCP Participating Provider in the Plan's Network of Providers. A Member is not obligated under this Plan to use *ProvenHealth Navigator®* services. The Member will incur a higher PCP Copayment if *ProvenHealth Navigator®* care is not selected by the Member. If a Member selects not to use a *ProvenHealth Navigator®* site for their primary care, they will not receive lower quality medical care. All Participating Providers are credentialed and monitored by the Plan for the quality of their care. A Member can choose at any time to use a *ProvenHealth Navigator®* site even if he or she has been using a non-*ProvenHealth Navigator®* PCP for Covered Services.

**** If the Member has any questions about ProvenHealth Navigator® services, please call the Customer Service Team at the number on the back of the Member Identification Card.***

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

2.4 **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.

2.5 **Choice of Primary Care Physician.** Upon enrollment, the Subscriber shall choose a Primary Care Physician for himself and for each enrolled Family Dependent. Any child Family Dependent shall be

entitled to have a pediatrician as his/her Primary Care Physician. The Provider List indicates the Primary Care Physicians and pediatricians who are part of the Plan's Network.

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

2.5.1 **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.

2.5.2 **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.

2.6 Member's Access to Covered Services. A Member may obtain Covered Services under the terms of this Certificate without obtaining a Referral from the Member's Primary Care Physician.

2.6.1 **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.

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

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

b) Upon meeting the Plan's standards, the Member may receive, in consultation with the Member's Primary Care Physician:

i) a standing Referral to a Specialist with clinical expertise in treating the disease or condition; or

ii) the designation of a Specialist to provide and coordinate the Member's primary and specialty care.

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

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

2.6.3 **Direct Access by Member.** The following Covered Services may be obtained directly by the Member without Prior Authorization.

2.6.3.1. **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.

2.6.3.2 **Access to Mental Health and Substance Abuse Services.** Members may select a Participating behavioral health Provider 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.

2.6.3.3 **Emergency Services**. Members may access Emergency Services as set forth in Section 3.8 of this Certificate.

2.7 Continuity of Care.

2.7.1 **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.

2.7.2 **Termination of Participating Provider or Participating Practitioner Without Cause.** The following definitions **apply only** to Section 2.7.2 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.

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

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

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

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

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

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

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

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

2.7.3 **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.

2.7.4 **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.

2.8 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 Advance Health Care Directive; or

c) through a properly appointed surrogate.

2.9 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.

2.9.1 **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.

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

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

b) Certain planned inpatient admissions and certain designated services and procedures require Prior Authorization.

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

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

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

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

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

h) Covered Services are subject to the terms and conditions of a Member's health benefit plan including any limitation of services and approved based on qualities or attributes which are determined by the Plan to be: (i) Medically Necessary; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available. The Plan's Medical Management staff utilizes nationally recognized, evidenced based criteria, as well as internally developed Medical Benefit Policies to determine Medical Necessity and appropriate levels of care. In the absence of criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations.

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 (i) from a Participating Provider (Section 3.1.1), (ii) when services from a Non-Participating Provider are Covered Services (Section 3.1.2), (iii) coverage parameters regarding the Covered Services (Section 3.1.3.), (iv) Covered Service Location Cost Sharing (Section 3.1.4); (v) Supplemental Health Services (Section 3.1.5) and (vi) 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 a Participating Provider.

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 3.8 of this Certificate;

b) Urgent Care as set forth in detail in Section 3.39 of this Certificate;

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

d) for Covered Services under this Certificate in accordance with the continuity of care provisions for new and existing Members as provided in Section 2.7 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 2.7 of this Certificate.

3.1.4 **Covered Service Location Cost Sharing**. Certain Covered Services (as indicated on the Member's Schedule of Benefits) will subject the Member to a Cost Sharing obligation based on the type of facility where the Covered Service is provided (examples include, but are not limited to, dental anesthesia and hospice services). This location Cost Sharing 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 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 3.29 and Exhibit 2 of this Certificate.

3.2 Amyloidosis – Center of Excellence

3.2.1 **Definition.** For purposes of this Section 3.2, Center of Excellence ("COE") shall mean a Participating Health Care Provider designated by the Plan. Members should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

3.2.2 **Amyloidosis.** Covered Services for the treatment of amyloidosis include evaluation by a multidisciplinary team, including but not limited to a board-certified specialist, nurse educator,

clinical pharmacist, and/or a case management professional. Additionally, when recommended by a Participating Provider at the COE, and upon prior authorization, medication for the treatment of amyloidosis is covered.

Members will first undergo evaluation at a COE. If treatment is recommended by a Participating Provider of the COE, the Plan will apply Medical Necessity criteria in conducting a prior authorization review.

Prior authorization is required for pharmacologic treatment for amyloidosis, and if a Member does not satisfy Medical Necessity criteria for pharmacologic treatment, the treatment will not be covered.

Members must be seen at a COE and any prescriptions must be written by a Provider at the COE for coverage of pharmacologic treatment. Members have the option of following with a Participating Specialist. Exceptions to the requirement that Members use a COE will be made on a case-by-case basis including logistical and/or clinical issues.

3.3 Cardiac Rehabilitation. Outpatient cardiac rehabilitation is covered subject to the Benefit Limit and Cost Sharing set forth on the Schedule of Benefits.

3.4 Chemotherapy Medications. The Plan will cover Medically Necessary, FDA approved Chemotherapy medications in the treatment of cancer. Such coverage will include Chemotherapy medications that are administered intravenously, injected, or orally. Prior Authorization may be required.

Coverage and Cost Sharing for a prescribed, orally administered Chemotherapy medication shall not be any less favorable than the coverage provided or Cost Sharing applicable for intravenously administered or injected Chemotherapy medications.

As used in this section, "Chemotherapy medication" means a medication prescribed by a treating health care practitioner that is necessary to kill or slow the growth of cancerous cells.

3.5 Diabetic Medical Equipment, Supplies, Prescription Drugs and Services. The following diabetic medical equipment, supplies, prescription drugs and services for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are covered if prescribed by a health care professional legally authorized to prescribe such items under law when provided 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.

3.5.1 **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.

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

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

3.5.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered when provided under the

supervision of a 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.

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

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

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

3.7 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.

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

3.8.1 **Definitions.** For the purposes of this Durable Medical Equipment, Orthotic Devices and Prosthetic Devices Section and Section 4.60 of **EXCLUSIONS**, the following definitions shall apply:

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

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

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

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

Examples of Rehabilitative Devices include but are not limited to a speaking board or other communication device for a Member who cannot speak and self-care/home management

training such as ADL (Activities of Daily Living) and compensatory training/instructions in the use of adaptive equipment.

Rehabilitative Devices do not include:

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

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

3.8.2 **Durable Medical Equipment (DME) and Related Supplies.** Upon Prior Authorization, the Plan will cover the cost of renting, or at its option, purchasing Medically Necessary DME and Related Supplies when prescribed in advance by a Participating Provider for use consistent with required Food and Drug Administration (FDA) approved labeling for the item. This benefit includes the cost of delivery and installation. Repair and replacement of DME is covered only to the extent required as a result of normal wear and tear. DME must be obtained from a Participating Provider. The Plan reserves the right to recover any DME purchased by the Plan when such device or piece of equipment is no longer Medically Necessary or in the event that the Member is not Compliant in utilization of the equipment as indicated in the course of treatment and determined by the Plan. Coverage of DME is subject to the Exclusions set forth in Section 4.60 of this Certificate.

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

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

3.8.3 **Orthotic Devices**. The Plan will pay for the purchase of Orthotic Devices when prescribed in advance by a Participating Provider or when approved in advance by the Plan. Orthotic Devices must be obtained from a Participating Provider unless authorized in advance by the Plan. Coverage of Orthotic Devices is subject to the Exclusions set forth in Section 4.60 of this Certificate.

3.8.4 **Prosthetic Devices**. The Plan will pay for the purchase of one (1) Prosthetic Device, or the replacement of component parts or modification of a Prosthetic Device every five (5) years when obtained from a Participating Provider subject to the Exclusions set forth in Section 4.60 of this Certificate. However, the following Covered Services are not subject to the five (5) year Benefit Limit set forth above:

(a) initial and subsequent Prosthetic Devices following a mastectomy to replace the removed breast or portions thereof; and

(b) contact lenses, including gas-permeable rigid contact lenses (known as RGP or GP lenses), for the treatment of progressive eye diseases, including but not limited to keratoconus.

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

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

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

3.9 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 3.8.1(d) and 3.8.1(e) and 3.8.2 of this Certificate.

3.9.1 **Emergency Services Protocol.**

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

b) If a Member requires hospitalization following an emergency, the Emergency Services Health Care Provider is responsible to notify the 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 Participating behavioral health 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 3.26, Oral Surgery**.** The need for these services must result from an accidental injury (not chewing or biting).

3.9.2 **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 only until the Plan determines the Member's condition has stabilized and the Member can be transported to a Participating Provider without suffering detrimental consequences or aggravating the Member's condition. Such transportation is not

subject to the Copayment amount (as set forth on the Schedule of Benefits) normally applied to transportation services.

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

The Primary Care Physician Cost Sharing shall apply in lieu of the emergency room Cost Sharing 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.

3.10 Foot Care Services. Foot care and treatment for disease, injury and related conditions of the feet are covered, except as set forth in Section 4.17 of this Certificate.

3.11 Gender Transition Services. Upon Prior Authorization, Medically Necessary gender dysphoria (discontent) and gender confirmation treatment is covered, including psychological evaluation and treatment, hormonal therapy, designated prevention and long-term care clinical and laboratory monitoring services, and surgical treatment.

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

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

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

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

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

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

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

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

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

3.12.4 **Cost Sharing**. Cost Sharing is based on the type of facility as set forth on the Schedule of Benefits under "Hospital and Ambulatory Surgical Center Services".

3.13 Hepatitis C – Center of Excellence

3.13.1 **Definition.** For purposes of this Section 3.13, Center of Excellence ("COE") shall mean a Participating Health Care Provider designated by the Plan. Members should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

3.13.2 **Hepatitis C.** Covered Services for the treatment of Hepatitis C include evaluation by a multidisciplinary team, including a board-certified specialist, nurse educator, clinical pharmacist, behavioral health provider, case management professional and social worker. Additionally, when recommended by a Participating Provider at the COE, and upon prior authorization, medication for the treatment of hepatitis C is covered.

Members will first undergo evaluation at a COE. If treatment is recommended by a Participating Provider of the COE, the Plan will apply Medical Necessity criteria in conducting a prior authorization review.

Prior authorization is required for pharmacologic treatment for Hepatitis C, and if a Member does not satisfy Medical Necessity criteria for pharmacologic treatment, the treatment will not be covered.

Members must be seen at a COE and any prescriptions must be written by a Provider at the COE for coverage of pharmacologic treatment. Members have the options of following with Participating gastroenterologist, hepatologist, infectious disease specialist or transplant specialist Providers. Exceptions to the requirement that Members use a COE will be made on a case by case basis including logistical and/or clinical issues.

3.14 Home Health Care. Home health care is covered only in the event a Member is homebound except as provided in Section 3.14.4. 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 3.22 of this Certificate.

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:

3.14.1 **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 another Participating Provider physician.

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

3.14.3 **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 the care is ordered by the Member's Primary Care Physician or another Participating Provider. Home health care services are, also subject to any specific Benefit Limits set forth in this Section 3 of the Certificate.

3.14.4 **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.

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

a) prescribed by a Primary Care Physician or another physician Participating Provider.

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.

3.15.1 **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 Certificate, for Covered Services not related to the Terminal Illness.

3.15.2 **Limitations.** Covered Services provided which are unrelated to the Member's Terminal Illness shall not be covered under the Plan's Hospice benefit, but shall be covered as set forth in the applicable provisions of the Members Certificate.

3.16 Hospital and Ambulatory Surgical Center Services.

3.16.1 **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; radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma; 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;

3.16.2 **Prior Authorization.** Certain planned inpatient hospital admissions require Prior Authorization.

3.16.3 **Duration of Benefit.** Except for mastectomy Covered Services as set forth in Section 3.19, 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.

3.17 Impacted Wisdom Teeth. Subject to Section 3.17.1 below, Cost Sharing set forth on the Schedule of Benefits and applicable Exclusions set forth in Section 4, the Plan will cover consultation and services related to the extraction of partially or totally bony impacted third molars when performed by a Participating Provider.

3.17.1 Hospital and Ambulatory Surgical Center services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, are covered if the hospital services are required for an existing medical condition unrelated to the dental or oral surgical procedure or as set forth in Certificate Section **3.12, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**. Such coverage must be authorized in advance by the Plan.

3.18 Implanted Devices. Unless specifically excluded, implanted devices including but not limited to those for purposes of drug delivery; cardiac assistive devices; cochlear implants and artificial joints are covered when medically necessary for correction of dysfunction or treatment of disease and when the implanted device is within the Provider's scope of practice.

3.18.1 **Cost Sharing.** Implanted devices for purposes of drug delivery are covered subject to the implanted device Cost Sharing specified on the Schedule of Benefits. Implanted devices not for purposes of drug delivery (such as cardiac assistive devices, cochlear implants and artificial joints) are covered subject to the Cost Sharing obligations based on the type of facility where the Covered Service is provided. The location Cost Sharing is in addition to any Cost Sharing obligation for the Covered Service being provided to the Member.

3.19 Infusion Therapy. Infusion therapy services are covered subject to the Cost Sharing set forth in the Schedule of Benefits.

3.20 Injectable Drugs. Injectable drugs are covered and subject to the Cost Sharing set forth in the Schedule of Benefits. Select injectable drugs are covered as set forth separately in Section 3.34.

3.21 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) all stages of reconstruction of the breast on which the mastectomy was performed; and

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

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

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

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

3.22 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the provider. Certified licensed nurse midwife Participating Provider services shall be covered only if obtained from a Participating Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.22 below.

3.22.1 **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 Copayment specified on the Schedule of Benefits. The inpatient hospital Copayment shall be limited to a maximum dollar amount per hospital admission as set forth on the Schedule of Benefits. A postpartum home health care visit within forty-eight (48) hours for early discharges is not subject to any Copayment amounts under this Section.

3.22.2 **Childbirth Preparedness Classes.** Childbirth preparedness classes for education focused on preparing for labor and the birth of a child are covered for pregnant female Members up to a $100 limit per Benefit Period. Such classes may not be related solely to child rearing. In order to be reimbursed by the Plan for a childbirth preparedness class, the Member must follow the requirements of Section 10.3 of the Certificate. However, the Member is **not required** to follow the claim form requirements set forth in Section 10.3.1 of the Certificate; instead, the Member should submit a copy of the Childbirth preparedness class receipt indicating the payment amount and the completion date of the class.

3.23 Medical Foods

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

(b) Amino acid-based elemental medical formula. Upon Prior Authorization, the usual and customary cost of amino acid-based elemental medical formula for infants and children is covered when such formula is ordered by a physician and administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowl syndrome. An amino acid-base elemental formula covered under this section is a formula made of 100% free amino acids as the protein source.

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

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

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

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

3.24.2 **Serious Mental Illness Inpatient Services.** The cost of inpatient services for the treatment of Serious Mental Illness, provided in a mental hospital or psychiatric unit of an acute hospital (including the cost of services provided by a psychiatrist, licensed clinical psychologist, or other licensed behavioral health professional), is covered. Mental Health Inpatient Services obtained

from a Participating behavioral health Provider are subject to the Participating Provider "Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.2.1 **Partial Hospitalization**. The cost of partial hospitalization services for the treatment of Serious Mental Illness provided through a partial hospitalization program is covered. Partial hospitalization services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.3 **Serious Mental Illness Outpatient Professional Mental Health Services**. The cost of outpatient professional services for the treatment of Serious Mental Illness provided by or under the direction of psychiatrists, licensed clinical psychologists, or other behavioral health professionals, is covered for either individual or group therapy (combined) per Benefit Period. Outpatient Professional Mental Health Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Outpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.3.1 **Partial Hospitalization**. The cost of partial hospitalization services for the treatment of Serious Mental Illness provided through a partial hospitalization program is covered. Partial hospitalization services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.4 **Non-Serious Mental Illness Inpatient Services.** The cost of inpatient services for the treatment of Non-Serious Mental Illness, provided in a mental hospital or psychiatric unit of an acute hospital, (including the cost of services provided by a psychiatrist, licensed clinical psychologist or other licensed behavioral health professional) is covered. Non-Serious Mental Illness Inpatient Services obtained from a Participating behavioral health are subject to the Participating Provider "Non-Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.4.1 **Partial Hospitalization.** The cost of partial hospitalization services for the treatment of Non-Serious Mental Illness provided through a partial hospitalization program is covered. Non-Serious Mental Illness partial hospitalization services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Non-Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits.

3.24.5 **Non-Serious Mental Illness Outpatient Professional Mental Health Services.** The cost of outpatient professional services for the treatment of Non-Serious Mental Illness provided by or under the direction of psychiatrists, licensed clinical psychologists, or other behavioral health professionals, is covered for either individual or group therapy (combined) per Benefit Period. Outpatient Professional Mental Health Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Outpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits.

3.25 Newborn Coverage. Newborn children are covered as Members from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary 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

3.33.1 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 6.2.2.2 or 9.6 of this Certificate (as applicable).

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

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

3.26.2 **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).

3.26.3 **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) audiologic determinations of pathology.

3.26.4 **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.

3.26.5 **General Anesthesia and Associated Medical Costs** provided in connection with an inpatient or outpatient oral surgery procedure are covered as set forth in Section 3.12 of this Certificate.

3.26.6 **Cost Sharing.** Cost Sharing for Oral Surgery is based on the type of facility as set forth on the Schedule of Benefits under "Hospital and Ambulatory Surgical Center Services".

3.27 Ostomy Supplies. The Plan will cover ostomy supplies and maintenance supplies (including but not limited to barrier wipes, pastes and tape), provided by a Participating Provider for Members who have had a surgical procedure which resulted in the creation of a stoma (an artificial opening in the body which remains after the surgery is completed).

3.28 Physician Services.

3.28.1 **Hospital and Ambulatory Surgical Center Physician Services.** The services listed in Section 3.16 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

a) **Hospital.** The services set forth in Section 3.16 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 3.16 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.

3.28.2 **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.

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

a) Preventive, diagnostic and treatment services listed below under Section 3.29, **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;

c) injectable drugs (including those injectable drugs listed in Section 3.34 of this Certificate) when determined by the physician to be an integral part of care rendered by the physician during a visit, limited to the amount of drug administered during the visit;

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

3.29 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:

3.29.1 **Periodic health assessments** provided upon a schedule advisable by the Member's Primary Care Physician including:

a) physical examination(s),

3.29.1.1 **Periodic Health Assessment Cost Sharing.** For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.28.1, above, refer to the Schedule of Benefits under "PHYSICIAN OFFICE SERVICES". The Cost Sharing associated with these Covered Services will differ depending upon whether the services were provided by a Primary Care Physician or a Specialist.

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

3.30 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered when the service is obtained from a Participating Provider, subject to the Benefit Limit and Cost Sharing set forth on the Schedule of Benefits.

3.31 Refractions. An examination to determine the refractive error of the eye is covered if provided by a Participating Provider who is a: (i) Doctor of Optometry; or (ii) Medical Doctor who specializes in Ophthalmology. Services are subject to the Cost Sharing set forth on the Schedule of Benefits and applicable Exclusions set forth in Section 4.

3.32 Rehabilitative Services.

3.32.1 **Physical and Occupational Therapy Services.** Physical and occupational therapy, on either an outpatient or inpatient basis, is covered; however, Prior Authorization is required for inpatient therapy services provided in a rehabilitation facility.

3.32.1.1 **Physical Therapy for Back/Neck-Related Pain**. Upon Prior Authorization, physical therapy for back/neck-related pain is covered. Cost Sharing applicable to the first ten (10) physical therapy visits for back/neck-related pain will be bundled into two (2) series of five (5) visits per series. Cost Sharing applicable to each series is noted on the Schedule of Benefits. Cost Sharing applicable to each visit subsequent to the tenth (10^{th}) visit is also noted on the Schedule of Benefits.

3.32.2 **Speech Therapy Services.** Speech therapy, on either an outpatient or inpatient basis is covered; however, Prior Authorization is required for inpatient therapy services provided in a rehabilitation facility.

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

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

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

3.34 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.

- Abecma (idecabtagene vicleucel)
- Abilify Maintena (aripiprazole)
- Abraxane (paclitaxel protein-bound)
- Actemra IV (tocilizumab)
- Adakveo (crizanlizumab-tmca)
- Adcetris (brentuximab vedotin)
- Advate (Antihemophilic Factor VIII, Recombinant, PFM)
- Adynovate (Antihemophilic Factor VIII, Recombinant (Pegylated))
- Afstyla (antihemophilic factor VIII (recombinant))
- Akynzeo IV (fosnetupitant/palonosetron)
- Aldurazyme (laronidase)
- Alimta (pemetrexed)
- Aliqopa (copanlisib)
- Alphanate (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- AlphaNine SD (Antihemophilic Factor IX, Human)
- Alprolix (Antihemophilic Factor IX, Recombinant, FC)
- Ameluz (aminolevulinic acid)
- Amondys 45 (casimersen)
- Andexxa (andexanet alfa)
- Aralast (alpha1-proteinase inhibitor, human)
- Aranesp (darbepoetin alfa)
- Aristada (aripiprazole Lauroxil)
- Arranon (nelarabine)
- Artesunate for Injection
- Arzerra (ofatumumab)
- Asceniv (immune globulin intravenous, human -slra)
- Asparlas (calaspargase pegol-mknl)
- Atryn (Antithrombin, Recombinant)

- Avastin (bevacizumab)^(see foot note)
- Aveed (testosterone undecanoate)
- Avsola (infliximab-axxq)
- Avycaz (ceftazidime/avibactam)
- Azedra (iobenguane I 131)
- Bavencio (avelumab)
- Baxdela IV (delafloxacin meglumine)
- Bebulin (Antihemophilic Factor IX Complex, Human)
- Beleodaq (belinostat)
- Bendeka (bendamustine hydrochloride)
- Benefix (Antihemophilic Factor IX, Recombinant)
- Benlysta (belimumab)
- Beovu (brolucizumab-dbll)
- Berinert (C1 esterase inhibitor, human)
- Besponsa (inotuzumab ozogamicin)
- Bivigam (immune globulin intravenous)
- Blenrep (belantamab mafodotin)
- Blincyto (blinatumomab)
- Botox (botulinum toxin type A)
- Breyanzi (lisocabtagene maraleucel)
- Brineura (cerliponase alfa)
- Cabenuva (cabotegravir and rilpivirine)
- Cablivi (caplacizumab-yhdp)
- Camcevi (leuprolide)
- Carimune (intravenous immune globulin)
- Carvykti (ciltacabtagene autoleucel)
- Cerezyme (imiglucerase)
- Cimzia IV (certolizumab pegol)
- Cinqair (reslizumab)
- Cinryze (C1 esterase inhibitor, human)
- Cinvanti (aprepitant)
- Clolar (clofarabine)
- Coagadex (Factor X (Human))
- Corifact (factor XIII concentrate)
- Cosela (trilaciclib)
- Cresemba (isavuconazonium sulfate)
- Crysvita (burosumab-twza)
- Cubicin/Cubicin RF (daptomycin)*
- Cutaquig (immune globulin subcutaneous, human -hipp)
- Cuvitru (subcutaneous immune globulin)
- Cyramza (ramucirumab)
- Dacogen (decitabine)*
- Dalvance (dalbavancin)
- Danyelza (naxitamab)
- Daptomycin
- Darzalex (daratumumab)
- Darzalex Faspro (daratumumab/hyaluronidase)
- Decitabine
- Dextenza (dexamethasone ophthalmic)
- Dexycu (dexamethasone ophthalmic)
- Duopa (carbidopa/levodopa

- Durolane (sodium hyaluronate)
- Durysta (bimatoprost)
- Dysport (botulinum toxin Type A)
- Elaprase (idursulfase)
- Elelyso (taliglucerase alfa)
- Eligard (leuprolide)
- Elitek (rasburicase)
- Eloctate (Antihemophilic Factor VIII, Recombinant, FC)
- Eloxatin (oxaliplatin)*
- Elzonris (tagraxofusp-erzs)
- Empaveli (pegcetacoplan)
- Empliciti (elotuzumab)
- Enhertu (fam-trastuzumab deruxtecan-nxki)
- Entyvio (vedolizumab)
- Epogen (epoetin alfa, recombinant)
- Epoprostenol Sodium
- Erbitux (cetuximab)
- Erwinaze (asparaginase)
- Esperoct (antihemophilic factor, (recombinant) glycopegylated-exei)
- Esperoct (turoctocog alfa pegol)
- Euflexxa (hyaluronate sodium)
- Evenity (romosozumab-aqqg)
- Evkeeza (evinacumab)
- Exondys 51 (eteplirsen)
- Eylea (aflibercept)
- Fabrazyme (agalsidase beta)
- Fasenra (benralizumab)
- Faslodex (fulvestrant)
- Feiba NF (Anti-inhibitor Coagulant Complex)
- Fensolvi (leuprolide)
- Feraheme (ferumoxytol)
- Fetroja (cefiderocol sulfate tosylate)
- Firmagon (degarelix)
- Flebogamma (intravenous immune globulin)
- Flolan (epoprostenol)*
- Folotyn (pralatrexate)
- Fulphila (pegfilgrastim-jmdb)
- Gamifant (emapalumab-lzsg)
- Gammagard (subcutaneous/intravenous immune globulin)
- Gammaked (subcutaneous/intravenous immune globulin)
- Gammaplex (intravenous immune globulin)
- Gamunex-C (subcutaneous/intravenous immune globulin)
- Gazyva (obinutuzumab)
- Gel-One (cross-linked hyaluronate)
- Gelsyn-3 (sodium hyaluronate)
- Gen Visc 850 (sodium hyaluronate)
- Givlaari (givosiran)
- Glassia (alpha1-proteinase inhibitor, human)
- Granix (tbo-filgrastim)
- Halaven-T (erubulin)
- Helixate FS (Antihemophilic Factor VIII, Recombinant)

- Hemlibra (emicizumab-kxwh)
- Hemofil M (Antihemophilic Factor VIII, Human)
- Herceptin (trastuzumab)
- Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)
- Herzuma (trastuzumab-pkrb)
- Hizentra (subcutaneous immune globulin)
- Humate-P (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- Hyalgan (hyaluronate sodium)
- hydroxyprogesterone caproate
- Hymovis (hyaluronan)
- Hyqvia (subcutaneous immune globulin/hyaluronidase)
- Idelvion (antihemophilic factor IX (recombinant))
- Ilaris (canakinumab)
- Ilumya (tildrakizumab-asmn)
- Iluvien (fluocinolone acetonide [ophthalmic implant])
- Imfinzi (durvalumab)
- Imlygic (talimogene laherparepvec)
- Inflectra (infliximab-dyyb)
- Injectafer (ferric carboxymaltose)
- Invega Hafyera (paliperidone palmitate)
- Invega Sustenna (paliperidone palmitate)
- Invega Trinza (paliperidone palmitate)
- Istodax (romidepsin)
- IVIG (intravenous immune globulin)
- Ixempra (ixabepilone)
- Jelmyto (mitoMYcin)
- Jemperli (dostarlimuab-gxly)
- Jevtana (cabazitaxel)
- Jivi (antihemophilic factor (recombinant), PEGylated-aucl)
- Kadcyla (ado-trastuzumab emtansine)
- Kalbitor (ecallantide)
- Kanjinti (trastuzumab-anns)
- Kanuma (sebelipase alfa)
- Kcentra (prothrombin complex concentrate)
- Kepivance (palifermin)
- Keytruda (pembrolizumab)
- Khapzory (levoleucovorin)
- Kimmtrak (tebentafusp-tebn)
- Kimyrsa (oritavancin)
- Koate-DVI (Antihemophilic Factor VIII, Human)
- Kogenate FS (Antihemophilic Factor VIII, Recombinant)
- Kovaltry (antihemophilis factor)
- Krystexxa (pegloticase)
- Kymriah (tisagenlecleucel)
- Kyprolis (carfilzomib)
- Lemtrada (alemtuzumab)
- Leukine (sargramostim)
- Leqvio (inclisiran)
- Libtayo (cemiplimab-rwlc)
- Lucentis (ranibizumab)
- Lumizyme (alglucosidase alfa)

- Lumoxiti (moxetumomab pasudotox-tdfk)
- Lupaneta (leuprolide acetate/norethindrone acetate)
- Lupron Depot (leuprolide acetate)
- Lutathera (lutetium lu 177 dotatate)
- Luxturna (voretigene neparvovec-rzyl)
- Macugen (pegaptanib)
- Makena (hydroxyprogesterone caproate injection)
- Margenza (margetuximab)
- Marqibo (vincristine sulfate liposome injection)
- Mepsevii (vestronidase Alfa-vjbk)
- Mircera (methoxy polyethylene glycol-epoetin beta)
- Mitosol (mitomycin)
- Monjuvi (tafasitamab)
- Monoclate-P (Antihemophilic Factor VIII, Human)
- Mononine (Antihemophilic Factor IX, Human)
- Monovisc (hyaluronan)
- Mozobil (plerixafor)
- Mvasi (bevacizumab-awwb)
- Mylotarg (gemtuzumab ozogamicin)
- Myobloc (rimabotulinumtoxin B)
- Naglazyme (galsulfase)
- Neulasta (pegfilgrastim)
- Neupogen (filgrastim)
- Nexviazyme (avalglucosidase alfa-ngpt)
- Nivepria (pegfilgrastim)
- Nivestym (filgrastim-aafi)
- Novoseven RT (Coagulation Factor VIIa, Recombinant)
- N-Plate (romiplostim)
- Nucala (mepolizumab)
- Nulibry (fosdenopterin)
- Nulojix (belatacept)
- Nuwiq (Antihemophilic Factor VIII, Recombinant)
- Nuzyra IV (omadacycline tosylate)
- Nyvepria (pegfilgrastim-apgf)
- Obizur (Antihemophilic Factor VIII, Recombinant, Porcine Sequence)
- Ocrevus (ocrelizumab)
- Octagam (intravenous immune globulin)
- Ogivri (trastuzumab-dkst)
- Olinvyk (oliceridine)
- Oncaspar (pegaspargase)
- Onivyde (irinotecan (liposomal))
- Onpattro (patisiran)
- Ontruzant (trastuzumab)
- Opdivo (nivolumab)
- Opdualag (nivolumab/relatimab-rmbw)
- Orbactiv (ortivancin)
- Orencia IV (abatacept)
- Orthovisc (hyaluronate sodium)
- Oxaliplatin
- Oxlumo (lumasiran)
- Ozurdex (dexamethasone [opthalmic implant])

- Padcev (enfortumab vedotin-ejfv)
- Panzyga (immune globulin intravenous, human - ifas)
- Parsabiv (etelcalcetide)
- Pepaxto (melphalan flufenamide)
- Perjeta (pertuzumab)
- Perseris (risperidone)
- Phesgo (pertuzumab, trastuzumab, and hyaluronidase)
- Pluvicto (lutetium Lu 177 vipivotide tetraxetan)
- Polivy (polatuzumab vedotin-piiq)
- Portrazza (necitumumab)
- Poteligeo (mogamulizumab-kpkc)
- Praxbind (idarucizumab)
- Prevymis (letermovir)
- Prialt (ziconotide)
- Privigen (intravenous immune globulin)
- Probuphine (buprenorphine)
- Procrit (epoetin alfa, recombinant)
- Profilnine SD (Antihemophilic Factor IX Complex, Human)
- Prolastin (alpha1-proteinase inhibitor, human)
- Prolia (denosumab)
- Provenge (sipuleucel-T)
- Radicava (edaravone)
- Rapivab (peramivir)
- Rebinyn (coagulation factor IX (recombinant), glycopegylated)
- Reblozyl (luspatercept-aamt)
- Recarbrio (imipenem/cilastatin sodium/relebactam)
- Recombinate (Antihemophilic Factor VIII, Recombinant)
- Remicade (infliximab)
- Remodulin (treprostinil)
- Renflexis (infliximab-abda)
- Retacrit (epoetin alfa-epbx)
- Retisert (fluocinolone acetonide [ophthalmic implant])
- Revcovi (elapegademase-lvlr)
- Riabni (rituximab-arrx)
- Risperdal Consta (risperidone microspheres)
- Rituxan (rituximab)
- Rituxan Hycela (rituximab/hyaluronidase)
- Rixubis (coagulation factor IX)
- Ruconest (C1 esterase inhibitor [recombinant])
- Ruxience (rituximab-pvvr)
- Rybrevant (amivantamab-vmjw)
- Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)
- Ryplazim (plasminogen, human-tvmh)
- Sandostatin LAR (octreotide)
- Saphnelo (anifrolumab-fnia)
- Sarclisa (isatuximab-irfc)
- Scenesse (afamelanotide)
- Signifor LAR (pasireotide)
- Simponi Aria (golimumab)
- Sivextro (tedizolid)
- Soliris (eculizumab)

- Somatuline Depot (lanreotide)
- Spinraza (nusinersen)
- Spravato (esketamine)
- Stelara (ustekinumab)
- Sublocade (buprenorphine)
- Supartz/Supartz FX (hyaluronate sodium)
- Supprellin LA (histrelin acetate)
- Surfaxin (lucinactant)
- Sustol (granisetron)
- Susvimo (ranibizumab implant)
- Sylvant (siltuximab)
- Synagis (palivizumab)
- Synribo (omacetaxine mepesuccinate)
- Synvisc (hylan G-F 20)
- Synvisc-One (hylan G-F 20)
- Tecartus (brexucabtagene autoleucel)
- Tecentriq (atezolizumab)
- Teflaro (ceftaroline fosamil)
- Tepadina (thiotepa)
- Tepezza (teprotumumab-trbw)
- Tezspire (tezepelumab-ekko)
- Thrombate III (Antithrombin III, Human)
- Thyrogen (thyrotropin alfa)
- Tivdak (tisotumab vedotin-tftv)
- Torisel (temsirolimus)
- Trazimera (trastuzumab-qyyp)
- Treanda (bendamustine)
- Trelstar (triptorelin)
- Tretten (Factor XIII A-Subunit)
- Triluron (hyaluronate and derivatives)
- Triptodur (triptorelin pamoate)
- Trisenox (arsenic trioxide)
- Trivisc (sodium hyaluronate)
- Trodelvy (sacituzumab govitecan)
- Trogarzo (ibalizumab-uiyk)
- Truxima (rituximab-abbs)
- Tysabri (natalizumab)
- Udenyca (pegfilgrastim-cbqv)
- Ultomiris (ravulizumab-cwvz)
- Unituxin (dinutuximab)
- Uplizna (inebilizumab)
- Vabomere (meropenem/vaborbactam)
- Vabysmo (faricimab)
- Vectibix (panitumumab)
- Velcade (bortezomib)
- Veletri (epoprostenol)*
- Viltepso (viltolarsen)
- Vimizim (elosulfase alfa)
- Visco-3 (sodium hyaluronate)
- Vistide (cidofovir)
- Visudyne (verteporfin)

- Vivitrol (naloxone injection)
- Vonvendi (von willebrand factor)
- Voraxaze (glucarpidase)
- VPRIV (velaglucerase alfa)
- Vyepti (eptinezumab-jjmr)
- Vyondys 53 (golodirsen)
- Vyvgart (efgartigimod alfa-fcab)
- Vyxeos (daunorubicin/cytarabine (liposomal))
- Wilate (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- Xembify (immune globulin subcutaneous, human -klhw)
- Xembify (immune globulin)
- Xenleta (lefamulin)
- Xeomin (incobotulinumtoxina)
- Xerava (eravacycline)
- Xgeva (denosumab)
- Xiaflex (collagenase clostridium histolyticum)
- Xipere (triamcinolone acetonide injectable suspension)
- Xofigo (radium RA 223 dichloride)
- Xolair (omalizumab)
- Xyntha (Antihemophilic Factor VIII, Recombinant, PAF)
- Yervoy (ipilimumab)
- Yescarta (axicabtagene ciloleucel)
- Yondelis (trabectedin)
- Yutiq (fluocinolone acetonide)
- Zaltrap (ziv-aflibercept)
- Zarxio (filgrastim-sndz)
- Zemaira (alpha1-proteinase inhibitor, human)
- Zemdri (plazomicin sulfate)
- Zepzelca (lurbinectedin)
- Zerbaxa (ceftolozane/tazobactam)
- Zevalin (ibritumomab tiuxetan)
- Ziextenzo (pegfilgrastim-bmez)
- Zilretta (triamcinolone acetonide)
- Zinplava (bezlotoxumab)
- Zirabev (bevacizumab-bvzr)
- Zolgensma (Onasemnogene Abeparvovec)
- Zulresso (brexanolone)
- Zynlonta (loncastuximab tesirine-lpyl)
- Zyprexa Relprevv (olanzapine)

* Generic available and also included on this list.
^ Cost share will not be applied for a diagnosis of Age Related Macular Edema

3.34.1 Cost Sharing.

(a) Cost Sharing for select injectable drugs shall be subject to the "Select injectable drugs" Cost Sharing set forth on the Schedule of Benefits when dispensed from physician stock and billed through the medical claims system; and/or

(b) Cost Sharing for select injectable drugs shall be subject to the Member's outpatient prescription drug Cost Share if such drugs are obtained from a specialty vendor. If the Member does not have an outpatient prescription drug benefit, select injectable drugs obtained from a specialty vendor are not covered; and/or

(c) Cost Sharing for certain select injectable drugs shall be subject to the "Home Health Care" Cost Sharing if such drugs are administered to Members in the home by designated home infusion Participating Provider(s).

3.35 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.

3.36 Spinal Injections. Upon Prior Authorization, professional services related to spinal injections for back/neck-related pain are covered when appropriate medical management criteria are met. Cost Sharing applicable to such professional services is noted on the Schedule of Benefits.

3.37 Substance Abuse. Substance Abuse Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Substance Abuse Services" Cost Sharing as set forth on the Schedule of Benefits. The following Substance Abuse services are covered:

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

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

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

3.37.2 **Inpatient Detoxification.** Detoxification and related medical treatment for Substance Abuse is covered when provided on an inpatient basis in a hospital Provider or in an inpatient non-hospital facility. Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Inpatient Hospital Detoxification Services" Cost Sharing as set forth on the Schedule of Benefits. The following inpatient Detoxification services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.37.3 **Acute Outpatient Opioid Detoxification Treatment**. Acute outpatient opioid Detoxification treatment is covered. Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Acute Outpatient Opioid Detoxification Treatment Services" Cost Sharing as set forth on the Schedule of Benefits.

3.37.4 **Substance Abuse Rehabilitation.** The following Substance Abuse rehabilitation services are covered.

3.37.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered. Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Non-Hospital Residential Rehabilitation Services" Cost Sharing as set forth on the Schedule of Benefits. The following Inpatient Non-Hospital Residential Care services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.37.4.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered. Services obtained from a Participating behavioral health Provider are subject to the Participating Provider "Outpatient Rehabilitation Services" Cost Sharing as set forth on the Schedule of Benefits. The following outpatient Facility rehabilitation services for Substance Abuse are covered when administered by an employee of the facility: physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.37.4.3 **Partial Hospitalization.** The Plan may authorize partial hospitalization services for Substance Abuse rehabilitation.

3.38 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.

3.39 Transplant Services and Authorization Requirements.

3.39.1 **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.

3.39.2 **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 do not require Prior Authorization and are covered when Medically Necessary and performed through a Participating Provider.

3.39.3 **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.

3.39.4 **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.

3.39.5 **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.

3.39.5.1 **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.

3.39.6 **Self-Administered Prescription Drugs.** Except as set forth in this Section 3.39.6, self-administered prescription drugs provided on an outpatient basis to Members are **NOT COVERED** except as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider if such a Rider is listed on the Schedule of Benefits as being in place with this Plan.

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

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

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

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

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

3.39.7 **Travel, Lodging and Meal Expense Reimbursement.** Certain expenses for travel, lodging and meals incurred in conjunction with the occurrence of a Member's transplant procedure will be reimbursed to a Member organ recipient, a Member donor and/or a non-Member donor of organs

(as applicable) at a two-hundred dollar ($200.00) daily limit up to a total maximum amount of five-thousand dollars ($5,000.00) per transplant in accordance with 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 of the back of the Member's Identification Card.

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

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

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

3.40.2 **Scheduled Services.** Medically necessary non-emergency ambulance transportation is covered when provided by Participating Providers and Prior Authorization has been received. These transports are subject to the Cost Sharing set forth on the Schedule of Benefits.

3.41 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.

3.41.1 **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.

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

3.43 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, fitting and/or insertion of a contraceptive device covered by this Certificate; and

b) services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Certificate in Sections 4.13 and 4.24).

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

SECTION 4. EXCLUSIONS

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

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

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

4.2 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.** If a Member has coverage under the Autism Spectrum Disorder Services Rider and requires services under such Rider, the terms and conditions of the Rider will determine the behavioral services available for the Member.

4.4 Blood or Other Body Tissue and Fluids, Including Storage. Blood, and the storage and banking of autologous and cord blood, body tissue and fluids is **NOT COVERED**.

4.5 Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.19 of this Certificate.

4.6 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**.**

4.7 Corrective Devices. The purchase, fitting, or adjustment of corrective devices including but not limited to, eyeglasses, contact lenses, and hearing aids, are **NOT COVERED**, except as may be explicitly provided in Section 3.7.4 Prosthetic Devices, Section 3.17 Implanted Devices, and under the terms of the following Rider: Eyewear.

4.8 Cosmetic Surgery. Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the Plan, is **NOT COVERED**, except as provided in Section 3.21, 3.33.1 or 3.33.2 of this Certificate.

4.9 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.**

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

4.11 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, 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: a) expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.26.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth), b) General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care as set forth in the Certificate, Section 3.12 and c) Impacted Wisdom Teeth as set forth in the Certificate, Section 3.17.

4.12 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate at Sections 3.4.3 and 3.39.6 or as set forth in **Exhibit 2, Preventive Services**, or as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider or the Autism Spectrum Disorder Services Rider if such Riders are listed on the Schedule of Benefits as being in place with this Certificate.

4.13 Drugs and Devices for Purposes of Contraception. Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of **Exhibit 2, Preventive Services** and an Outpatient Prescription Drug Rider with Contraceptive coverage if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.

4.14 Elective Abortions. Abortions are **NOT COVERED** except for those which have been deemed to be Medically Necessary through Prior Authorization to avert the death of the mother or to terminate pregnancy caused by rape or incest.

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

4.16 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**.

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

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

4.19 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**.

4.20 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 Prior Authorizations must be obtained even when the Plan is the secondary carrier.

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

4.22 Hypnosis. Hypnosis is **NOT COVERED**.

4.23 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**.

4.24 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**.

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

4.26 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**.

4.27 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 Manipulative Treatment Services Rider if such Rider is listed on the Schedule of Benefits as being in place with this Certificate.

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

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

4.30 Intentionally left blank.

4.31 Non-Participating Providers. Covered Services or supplies received from Non-Participating Providers are **NOT COVERED**. The only exceptions are:

a) Emergency Services, as provided in Section 3.9 of this Certificate;

b) Urgent Care received outside the Service Area, as provided in Section 3.41 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 2.7 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.

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

4.33 **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**.

4.34 **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 3.29, **Preventive Services**.

4.35 **Oral Nutrition Products or Supplements**. Oral nutrition products or supplements used to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc., are **NOT COVERED** including, but not limited to, lactose free foods; banked breast milk; and/or standardized or specialized infant formulas.

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

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

4.38 **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.

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

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

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

4.42 **Prescription Bandages and Wound Dressings**. Prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in Section 3.27 of this Certificate.

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

4.44 **Refraction Examinations.** Refractive examinations are covered as set forth in Section 3, Covered Services; however, the following are **NOT COVERED**:

i) Optical materials (eyeglasses, contact lenses) or their fitting, repair or replacement.
ii) Additional ophthalmological services provided during the same visit as the refractive exam, unless such services provided for in the Certificate.

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

4.46 **Reversal of Genital Surgery.** Surgical procedures to reverse genital surgery are **NOT COVERED**, except as stipulated in Section 4.53, Services Provided in Conjunction with a Non-Covered Service.

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

4.48 **Reversal of Surgery to Revise Secondary Sex Characteristics.** Surgical procedures to reverse secondary sex characteristic surgery are **NOT COVERED**, except as stipulated in Section 4.53, Services Provided in Conjunction with a Non-Covered Service.

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

4.53 Services Provided in Conjunction with a Non-Covered Service. Any service, which would otherwise be a Covered Service under this Certificate, when provided in conjunction with the provision of a non-Covered Service, is **NOT COVERED**. Such services may include but are not limited to anesthesia or diagnostic services. This exclusion does not include Medically Necessary Covered Services incurred due to complications resulting from a Member's receipt of a non-Covered Service or General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.12.

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

4.55 Surrogate Services. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and pre-natal/delivery/post-natal services are **NOT COVERED.**

4.56 Transportation Services. Stretcher van and/or wheelchair van transportation services are **NOT COVERED**.

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

a) provided by the Member's Primary Care Physician or another Participating Provider 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 a Participating behavioral health Provider; or

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

Emergency Services provided inside or outside the Service Area do not require authorization. See Section 3.8 of this Certificate for the Emergency Services protocol.

4.58 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.

4.59 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.44 of this Certificate or as set forth in **Exhibit 2, Preventive Services**.

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

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

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

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

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

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

4.60.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** of any sort are **NOT COVERED**, except for diabetic foot orthotics which are covered as a Covered Service under Section 3.4.2 of this Certificate and/or AposTherapy.

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

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

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

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

4.60.11 **Experimental or Research Equipment** which, as determined by the Plan, is not accepted as standard medical treatment of the condition being treated, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device, Orthotic Device or DME was provided is **NOT COVERED**. The experimental or non-experimental nature of any Prosthetic Device, Orthotic Device, or DME shall be determined by the Plan in accordance with the terms and conditions set forth in Section 1.21 of this Certificate.

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

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

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

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

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

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

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

4.60.19 **Repair or Replacement** of any piece of equipment/device, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in Section 3.7.2 of this Certificate.

4.60.20 **Replacement of Component Parts or Modification** of a Prosthetic Device within five (5) years of obtaining a new or other replacement part(s) is **NOT COVERED** unless specifically provided for in Sections 3.7.4 and 3.7.4.1 of this Certificate.

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

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

4.61 Costs associated with the following are **NOT COVERED**:

a) Group Homes;
b) Half-Way Houses;
c) Temporary Lodging Facilities;
d) Sober Living Home/housing.

SECTION 5. COMPLAINT AND GRIEVANCE PROCEDURE

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

5. COMPLAINT AND GRIEVANCE PROCEDURE.

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

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

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

5.1 Complaint Procedure.

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

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

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

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

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

b) the outcome of the first level review;

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

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

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

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

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

h) 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;

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;

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.

5.2 Grievance /Adverse Benefit Determination.

5.2.1 **First Level Grievance Review Procedure.** A Member or a Health Care Provider with the Member's written consent, may file a **written** request (or an oral request by a Member who is unable to file a written Grievance by reason of disability or language barrier) to have the Plan review the Grievance. This request must be filed within one hundred eighty (180) calendar days following receipt of notification of 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;

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

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

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

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

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

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

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

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

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

Within one (1) business day after completion of the preliminary review, the Plan must issue written notification to the Member. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact

information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete. To complete an incomplete request, the Member will have either the remainder of the four (4) month filing period (as detailed in Section 5.4.1) or within forty-eight (48) hours following the receipt of the notification, whichever is later.

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

a) The Member's medical records;

b) The attending health care professional's recommendation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5.2 **External Review Procedure**. If an external review is warranted, the Plan will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The Plan will provide all the necessary documents and information considered in making the Final Adverse Benefit Determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.1.2. In reaching a decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during the Plan's internal appeal procedures.

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

SECTION 6. ELIGIBILITY

NOTE: Effective January 1, 2020, the Plan's retroactive enrollment window will increase to sixty (60) days if the Member experiences a qualifying event.

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) (i) a full-time resident of the Service Area or (ii) work within the Service Area and live within twenty (20) miles or thirty (30) minutes 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 under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania.

b) A Subscriber's child (married or unmarried) who has not yet attained the age of twenty-six (26) is eligible for enrollment as follows.

1) Eligible children of the Subscriber include:
   i) natural children and
   ii) stepchildren.

2) Eligible children of the Subscriber and/or the Subscriber's spouse who is an enrolled Member under this Plan include:
   i) children legally placed for adoption;
   ii) children awarded coverage pursuant to an order of court;
   iii) legally adopted children; and
   iv) foster children who are placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Family Dependents may live within or outside the Service Area but benefits will be limited to those as set forth in this Certificate.

Eligibility shall cease for a dependent child on the last day of the month in which the dependent child becomes age 26 (except for disabled dependent children).

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

6.2.1 **New Spouse.** A newly married Subscriber may arrange for Family Coverage by enrolling his or her spouse in the Plan within sixty (60) 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.

6.2.2 **Newborn Child(ren).**

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

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

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

(ii) The Subscriber must contact their Employer Group's personnel or human r resources department within sixty (60) days from the date of the newborn's birth to complete the appropriate enrollment forms for continued coverage of the newborn under this Certificate.

OR

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

(ii) within sixty (60) days from the newborn's birth, the newborn's parent(s), Legal Guardian, or Legal Custodian may convert to a separate individual policy, offering similar benefits to this Certificate, on behalf of the newborn.

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

6.2.3 **Adopted Child.** A legally adopted child or a child for whom a Subscriber or the Subscriber's eligible dependent spouse is a court appointed Legal Guardian or Legal Custodian and who meets the definition of a Family Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The

placement must take effect on or after the date a Subscriber's coverage becomes effective and the Subscriber must make a written request for coverage within sixty (60) days of the date the child is adopted or placed with the Subscriber or the Subscriber's eligible dependent spouse for adoption.

An adopted child or a child placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse is automatically covered under this Certificate for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from single to Family Coverage) must be submitted to the Plan within sixty (60) days of the date of adoption or date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. The Plan will require documentary proof (i.e., official court documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage.

6.2.4 **Intentionally left blank.**

6.2.5 **Continued Coverage of Disabled Dependent Child.** A dependent child (married or unmarried) who exceeds the Maximum Age for dependent children may continue enrollment under the Plan when the following conditions are met:

a) the child is incapable of self-sustaining employment by reason of disability resulting from mental retardation or a physical disability and the child became so prior to the attainment of age nineteen (19); and

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

In order to continue coverage of a disabled dependent child, the Subscriber must provide evidence to the Plan of the child's incapacity and dependency within sixty (60) days of the date the child's coverage would otherwise terminate. The Plan may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the Plan is first notified of such disability and dependency, whichever is earlier.

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

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

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

(i) submit a form approved by the Department of Military and Veterans Affairs notifying the 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.

For purposes of this section, a full-time student shall be an individual who enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than twelve (12) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study. The Plan may periodically require documentary proof of enrollment as student upon reaching the Maximum Age for dependent children set forth on the Schedule of Benefits, or upon the date of which the Plan is first notified of such enrollment.

6.2.7 **Noncustodial Children.** A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order (collectively referred to as "Order").

(a) The Plan will require documentary proof (i.e., official court order or qualified medical support order) evidencing the obligation of the Subscriber to provide health care coverage together with a written application to the Plan for membership of such child.

(b) The written application for membership must be received by the Plan within sixty (60) days of the Plan's receipt of the Order. A noncustodial child will not be enrolled without timely receipt by the Plan of a written application.

(c) The effective date of membership in the Plan for a noncustodial child will be determined as follows:

(i) If an Order is received by the Plan within 60 days of the date of the Order AND the written application has been received by the Plan in accordance with subsection (b) above, then the effective date of coverage for the noncustodial child under the Plan will be the effective date of coverage as directed in the Order.

(ii) If the Order is received by the Plan more than 60 days after the date of the Order AND the written application has been received by the Plan in accordance with subsection (b) above, then the effective date of coverage for the noncustodial child under the Plan shall be effective the first day of the next calendar month following the Plans receipt of the Order.

(d) 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.

(e) The Plan may not disenroll or eliminate coverage of any child unless the Plan is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

6.3 Continued Eligibility During Military Service. If a Subscriber is called to Active Military Duty (for the purpose of this Section only, Active Military Duty is defined as voluntary or involuntary duty in a uniformed service under competent authority), coverage will continue under the Plan for the first thirty (30) days of the Active Military Duty. After the expiration of the first thirty (30) days, the Subscriber will be given the option of continuing health care coverage at their own expense through a COBRA or

Mini-COBRA offering, as applicable for themselves and their eligible Family Dependents. This offering will be at the same rate paid by the employer for the Subscriber's and the Subscriber's eligible Family Dependents' coverage. The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.19 of this Certificate.

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

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

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

b) have properly elected to receive COBRA coverage.

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

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

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

6.4.1 **Post-COBRA Conversion Coverage**. A Subscriber and/or eligible Family Dependents shall be entitled to obtain a conversion policy upon termination of COBRA coverage according to the terms and conditions set forth in Section 9.3.11 of this Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

6.5.2 **Post Mini-COBRA Conversion Coverage.** A Subscriber and eligible dependents shall be entitled to obtain a conversion policy upon termination of Mini-COBRA coverage according to the terms and conditions set forth in Section 9.3.11 of this Certificate.

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

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

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

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

Only a Member for whom the premium is actually received by the 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.

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

6.6.2 **Non-Open Enrollment Period Application.** Any individual who first satisfies the eligibility requirements and who makes written application for membership at a time other than an Open Enrollment Period but within sixty (60) days of initially attaining eligibility shall become effective on the day following the last day of coverage with the prior health benefit program, except for:

a) newly married spouses, newborns, adopted children, foster children, or children placed for adoption, whose dates of coverage are established by law; and noncustodial children of a Subscriber when the Subscriber receives an official court order or a qualified medical support order to provide health care coverage for such noncustodial child(ren).

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 sixty (60) days of initially attaining eligibility shall NOT be eligible to enroll until the next Open Enrollment Period.

6.7 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the 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 sixty (60) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a special enrollment period.

6.8 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 sixty (60) 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.

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

a) An individual and any dependent(s) each are eligible for special enrollment in any benefit package under the Plan (subject to Plan eligibility rules) if (i) the individual and their dependents are otherwise eligible to enroll in the benefit package; (ii) when coverage under the Plan was previously offered, the individual and their dependents had coverage under any group health plan **or** health insurance coverage; (iii) the individual declined enrollment, in writing, for himself and any family dependent, stating that the coverage under another group health plan or health insurance coverage was the reason for declining enrollment; and (iv) loss of eligibility under the other group health benefit program was as a result of one of the following qualifying events:

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) exhaustion of the COBRA or Mini-COBRA maximum period of coverage (for COBRA or Mini-COBRA eligible Groups),
vii) no longer working or residing in the service area when the other group health benefit program (such as an HMO) does not provide benefits to an individual who no longer works or resides in the service area, or
viii) loss of dependent status.

b) An individual and a new dependent each are eligible for special enrollment in any benefit package under the Plan (subject to Plan eligibility rules) if the individual and their new dependent are otherwise eligible to enroll in the benefit package and the individual gains the new dependent or becomes a new dependent through marriage, birth, adoption, or placement for adoption or foster care.

6.8.1.1 **Length of Special Enrollment Period.** A qualified individual or his or her dependent has sixty (60) days from the date of a qualifying event to apply for enrollment in this Plan.

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

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

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

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

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

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

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

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

6.11 Notice of Ineligibility. It shall be the Subscriber's responsibility to notify the Group or the Plan of any changes which will affect the Subscriber's eligibility or that of a Family Dependent for Covered Services or benefits under this Certificate within sixty (60) 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.

7.2.1 **Adjustment of Premium based on Class**. The Plan reserves the right to change the premium on a class basis.

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 sixty (60) 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 or Coinsurance amounts incurred by the Subscriber or any Family Dependents during the grace period.

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

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 determine the Primary Plan/Secondary Plan. The benefits of This Plan:

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

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

8.2.3 **Order of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

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

Period or Program year during which any benefits are actually paid or provided before the entity has that actual knowledge.

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

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

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

a) This Section applies when, under the above Section of the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one 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;

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.**

8.2.10 The benefits paid by the Plan will be secondary to any no-fault auto insurance benefits and to any workers' compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.

8.3 Subrogation and Reimbursement Rights.

8.3.1 In General. The Plan has the right of subrogation and reimbursement rights to the maximum extent permitted by law against Members and third parties who are legally liable for, or receive any type of payment, reimbursement, settlement, award or judgment in connection with any expenses paid by the Plan under this Certificate. The Member shall do nothing to prejudice the subrogation or reimbursement rights of the Plan.

For purposes of this Section 8.3, the term "Responsible Third Party" shall include, but not be limited to, any (i) person or entity, including any insurance company or indemnifier, employer in a workers' compensation case or other matter alleging liability, person or entity who is or may be obligated to pay benefits to the Member (including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage, workers' compensation coverage, other insurance carriers or third party administrators), (ii) person or entity against whom the Member may have a claim for professional malpractice, or any other equitable or legal liability theory, or (iii) health benefits plan or other third party, which has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to a Member for an injury or illness, in each case, where the Plan provided medical care or benefits to, or incurred expenses for or on behalf of, the Member in connection therewith.

8.3.2 Subrogation Rights. Subrogation rights arise when the Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Plan "stands in the Member's shoes" or "in the shoes" of any other person and assumes the right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Plan has reimbursed the Member for medical expenses or paid medical expenses on behalf of a Member. The right to pursue a subrogation claim is not contingent upon whether a Member pursues the Responsible Third Party for any recovery or declines to do so.

Subrogation Example. The Member is injured in an accident that is not the Member's fault and receives benefits under the Plan to cover the Member's injuries. Under this subrogation provision, the Plan has the right to take legal action in the Member's name against the individual who caused the accident and that individual's insurance carrier to recover the cost of those benefits.

8.3.3 Reimbursement Rights. If a Member obtains any recovery - regardless of how it is described or structured - from a Responsible Third Party, the Member must fully reimburse the Plan out of the amounts recovered from the Responsible Third Party for all medical expenses that were paid to the Member or on

the Member's behalf to the extent permitted by law. The Plan has the right to pursue recovery of the full reimbursement amount.

Reimbursement Right Example. The Member is injured in an accident that is not the Member's fault and receives benefits under the Plan to cover the Member's injuries. In addition, the Member receives a settlement in a court proceeding from the individual who caused the accident. The Member must use the settlement funds to reimburse the Plan 100% of the cost of any benefits the Member received from the Plan.

8.3.4 General Rules Governing Subrogation and Reimbursement. The Plan's subrogation and reimbursement rights shall apply regardless of whether the funds sought by the Plan were obtained or received by a Member or any third party through a court or an arbitrator's decision, settlement, or any other type of resolution. The Plan's subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering). The Plan's subrogation and reimbursement rights apply with respect to any recoveries made by Member, including amounts recovered under an uninsured or underinsured motorist policy. The Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Plan agrees to do so in writing. The Plan's subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All of the Plan's subrogation and reimbursement rights are enforceable against the heirs, estate, legal guardians or legal representatives of the Member. The Plan has the right to pursue recovery of the full reimbursement amount of the medical benefits paid by the Plan without regard to any claim of fault on the part of the Member.

The Plan has a first priority right /equitable lien to receive payment on any claim against any third party before a Member is entitled to receive payment from that third party. This first priority right/equitable lien is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable by or recovered from a Responsible Third Party and/or insurance carrier.

Regardless of whether a Member has been fully compensated or made whole, the Plan may collect from the Member any proceeds of any full or partial recovery that the Member or the Member's legal representative obtains, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. The "Made-Whole" or "Make-Whole" Doctrine and the "Common Fund" Doctrine shall not in any way limit the Plan's subrogation and reimbursement rights and may not be used in any way to reduce the Plan's recovery under its subrogation and reimbursement rights. No collateral source rule, no claim of unjust enrichment and no other equitable limitation shall in any way limit the Plan's subrogation and reimbursement rights or shall in any way reduce the Plan's recovery under its subrogation and reimbursement rights.

8.3.5 Obligations of a Member. A Member who asserts a claim against a Responsible Third Party must immediately notify the Plan in writing of the claim, regardless of whether it is asserted informally or through judicial or administrative proceedings. Whenever a Responsible Third Party or its representative contacts a Member or the Member's representative, and whenever a Member contacts a Responsible Third Party or its representative for the purpose of discussing a potential settlement or resolution, the Member must immediately notify the Plan in writing. A Member must refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury or illness for which the Plan provided medical care or any benefits in any way, unless and until the Plan provides its written authorization to accept the offer. A Member must fully cooperate with the Plan, as needed, to allow for the enforcement of these subrogation and reimbursement rights, promptly supply information/documentation when requested, and promptly execute any and all forms/documents that may

be needed by the Plan to fully exercise its reimbursement and subrogation rights. This includes providing the Plan with any relevant information it requests, signing and delivering such documents as the Plan or its agents reasonably request to secure the subrogation and/or reimbursement claim, providing testimony, and making court appearances. A Member must avoid taking any action that may prejudice or harm the Plan's ability to enforce its subrogation and reimbursement rights to the fullest extent possible. A Member must fully reimburse the Plan promptly, if appropriate, out of the amounts recovered from the Responsible Third Party whether the funds are received by court judgment, settlement or otherwise from a Responsible Third Party. All of these obligations of a Member apply to the heirs, estate, legal guardians or legal representatives of the Member.

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 By the Group.**

- At least 30 days prior to the conclusion of the grace period as described in Section 7.4 (Grace Period), the Plan shall provide written notice to the Group of Group's failure to pay premium.

- At least 15 days prior to the conclusion of the grace period as described in Section 7.4 (Grace Period), the Plan shall provide separate written notices to both the Group and the Subscriber.

  - The notice to Group shall be a final notice of termination due to non-payment of premium and include, among other things, the amount of premium due, the due date and notice that employee coverage will be terminated if premium is not paid by such date.

  - The notice to Subscriber shall provide notice of the Group's failure to pay premium and what will happen to the Subscriber's coverage if the Group fails to pay premium.

- Following the conclusion of the grace period as described in Section 7.4 (Grace Period), if the Group fails to pay any amount due the Plan, for the benefits of the Subscriber or any Family Dependents, coverage shall terminate for the Subscriber and all Family Dependents. The effective date of the termination shall be the end of the grace period.

- A Member whose coverage is terminated due to the Group's failure to pay pursuant to this Section may be eligible for conversion to individual, direct payment coverage, 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.

9.3.2 **Fraud or Material Misrepresentation.**

9.3.2.1 **By the Group.** In the event the Group makes an intentional misrepresentation of a material fact for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. For termination of coverage with a retroactive effect, thirty (30) days advance written notice will be provided to each 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 a 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. For termination of coverage with a retroactive effect, thirty (30) days advance written notice will be provided to the Subscriber. This decision may be appealed through the Plan's established Complaint procedure as set forth in Section 5 of this Certificate.

9.3.3 **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 or Failure to Meet 20/30 Rule.** To be eligible to enroll and to continue enrollment in the Plan, the Subscriber must (i) be a full-time resident of the Service Area or (ii) work within the Service Area and live within twenty (20) miles or thirty (30) minutes of a Participating Primary Care Physician. If the Subscriber is (i) absent from the Service Area for more than ninety (90) consecutive days or (ii) works within the Service Area but no longer lives within twenty (20) miles or thirty (30) minutes of a Participating Primary Care Physician, such Member shall no longer be considered a permanent resident of the Service Area and coverage for the Subscriber and all Family Dependents shall be terminated upon fifteen (15) days written notice by the Plan to the Subscriber.

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

9.3.9 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage 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 **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, if coverage terminated under the Certificate because the Member failed to pay required premium contributions, or if the Member is or could be covered by Medicare. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA or Mini-COBRA eligible Groups) are eligible for conversion coverage when their COBRA or Mini-COBRA eligibility for Group coverage expires.

The Plan will give the Member written notice of the conversion privilege within fifteen (15) days before or after the date of termination of coverage. The Member must apply for Conversion Coverage and pay the applicable premiums within thirty-one (31) days after the termination of coverage under the Certificate, or within fifteen (15) days after the Plan provides the Member notice of conversion rights, whichever is later.

The Member may enroll in Conversion Coverage without a medical examination. The first premium payment must be received before Conversion Coverage will be put in force. Conversion Coverage shall begin the day after termination of coverage under the Certificate.

9.4 Reinstatement.

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

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

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

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

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

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

1) until the inpatient stay ends; or
2) until any applicable Benefit Limit has been reached; or
3) until the Member becomes covered without limitation as to the condition for which he or she is receiving inpatient care under any other group coverage; or

4) up to the end of the Benefit Period;

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

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

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

10.6 Modifications. 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 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 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.

10.15 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 Certificate which is necessary in order to accomplish such purpose, provided that the changes described in such Amendment are made on a uniform basis consistent with the provisions of HIPAA.

10.16 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 Policy shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

10.17 Fraud and Abuse. There may be times when a Member needs to report fraud or abuse they have observed. This could be fraud and abuse by a Member or a Provider. Health care fraud is an intentional misrepresentation, deception, or intentional act of deceit for the purpose of receiving greater reimbursement. Abuse is reckless disregard or conduct that goes against and is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement.

To report suspected fraud or abuse, a Member can call the Plan's fraud and abuse hotline at **1-800-292-1627**. The Member does not have to give their name if they call the hotline, but if they do, it will be kept confidential. The hotline is available 24 hours, seven (7) days a week.

Examples of fraud and abuse are:

Examples of Fraud

- Submitting claims for services not provided or used.
- Falsifying claims or medical records.
- Misrepresenting dates, frequency, duration or description of services rendered.
- Billing for services at a higher level than provided or necessary.
- Falsifying eligibility.
- Failing to disclose coverage under other health insurance.

Examples of Abuse

- A pattern of waiving Cost Sharing.
- Failure to maintain adequate medical or financial records.
- A pattern of claims for services not medically necessary.
- Refusal to furnish or allow access to medical records.
- Improper billing practices.

10.18 Headings. The headings of sections and paragraphs contained in this Certificate are for reference purposes only and shall not affect in any way the meaning or interpretation of the Certificate.

10.19 Non-Discrimination. The Plan does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, genetic information or health status in the administration of the plan, including enrollment and benefit determinations.

10.20 Time Limit on Certain Defenses.

10.20.1 Material Misstatements. Material misstatements made by the applicant in connection with the Certificate will, at the option of the Plan, permit the Plan to void the Certificate or deny claims, provided such material misstatement is discovered by the Plan within three (3) years of the date of issue of the Certificate.

10.20.2 Intentional Misrepresentation of a Material Fact. Intentional misrepresentation of a material fact made by the applicant in connection with the Certificate will, at the option of the Plan, render the Certificate void from inception, provided such intentional misrepresentation of a material fact is discovered by the Plan within three (3) years of the date of issue of the Certificate.

10.21 Assignment of Benefit to Providers. The right of a Member to receive benefit payments under this Certificate is personal to the Member and is not assignable in whole or in part to any person, hospital, or other entity nor may benefits of this Certificate be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under this Certificate, as required by law.

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, Fulton, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York.

(In Bedford County, only areas within the listed U.S. Postal Service zip codes identified below are included):

BEDFORD COUNTY
- *the following zip codes only:*
15521
15554
16633
16650
16655
16659
16664
16667
16670
16672
16678
16679
16695

Exhibit 2
Preventive Covered Services

Preventive care

Everyone wants to stay healthy, happy and living the life they love. That's why we provide the highest standard of preventive care services recommended by state and federal agencies like the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices for immunizations, the American Academy of Pediatrics and others. Visit the immunization schedule section at cdc.gov for more information.

Many of the preventive services listed are covered with no member cost sharing at a participating or preferred doctor. (There may be cost sharing if a doctor provides additional services that aren't part of the preventive care list.)

From health screenings to vaccination reminders and everything in between, we're here to help make better health easier for everyone.

Well baby and well child exams and immunizations – newborn to age 21

Service	Coverage
Anemia	• 4 months based on risk assessment • 12 months • 15 months to age 21 based on risk assessment
Autism spectrum disorder screening	• 18 and 24 months
Behavioral/Social/Emotional Screening	• Annually from newborn to 21 years
Blood pressure	• Newborn to 30 months based on risk assessment, then annually ages 3 to 21
Body mass index (BMI)	• 24 months, 30 months, then yearly to age 21
Congenital hypothyroidism screening	• All newborns • Note: Infants born premature, ill or with very low birth weight may benefit from more than one screening due to decreased sensitivity and specificity of screening
Critical congenital heart defect	• At birth
Depression and Suicide Risk screening	• Annually age 12–21 years
Developmental screening	• 9, 18 and 30 months
Developmental surveillance	• Newborn, 3-5 days • 1-6 months; 12, 15, 24 months; annually age 3–21 years
Dyslipidemia (cholesterol/lipid disorders)	• 24 months based on risk assessment • Years 4, 6, 8, 9-11, 12, 13, 14, 15, 16, 17-21 years based on risk assessment
Fluoride supplementation	• 6, 9, 12, 18, 24, 30 months; then annually age 3–16 years based on risk assessment
Fluoride varnish	• 6 months to 5 years
Hearing screening *Note: Not complete hearing examination*	• Newborn, 3–5 days to 2 months, 4 months to 3 years based on risk assessment, annually ages 4–6, 8 years, 10 years, between 11 and 14 years, between 15 and 17 years, and between 18 and 21 years • Other years based on risk assessment

History, length/height, weight, head circumference and physical exam	• Newborn to 24 months • Additional visit at 2-4 days for infants discharged less than 48 hours after delivery
HIV	• 11, 12, 13, 14 years based on risk assessment • Once between ages 15–18 years • Ages 19 – 21 based on risk assessment
Immunizations *Note: Immunizations necessary for international travel are not covered*	• Newborn to age 21 following the American Academy of Pediatrics Immunization Schedule https://publications.aap.org/redbook/pages/immunization-schedules • Questions about immunization coverage? Call the number on the back of your member ID card.
Lead	• 6, 9, 12, 18, 24 months based on risk assessment • Years 3-6 based on risk assessment
Maternal depression screening	• 1, 2, 4 and 6 months at well-child visits
Metabolic/hemoglobinopathies	• According to state law • All newborns
Newborn bilirubin	• At birth
Newborn blood draw	• At birth, 3–5 days • Additional blood draws based on risk assessment
Obesity screening	• Age 6 years and older
Oral health	• 6 and 9 months • 12, 18, 24, 30 months and annually age 3–6 years based on risk assessment
PKU screening	• At birth
Prophylactic ocular (eye) medication to prevent blindness secondary to gonococcal ophthalmia neonatorum	• All newborns
Sexually transmitted infections	• Annually age 11–21 years, based on risk assessment
Sickle cell disease screening	• All newborns
Tobacco, alcohol or drug use assessment	• Age 11–21 years based on risk assessment
Tobacco Use in Children and Adolescents: Primary Care Interventions	• Interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents who have not started to use tobacco
Tuberculosis	• Months 1, 6, 12, 24 and yearly from age 3 based on risk assessment
Vision screening *Note: Not complete eye examination*	• Newborn to 30 months based on risk assessment, annually age 3–6 years, then every other year until and including age 15 (or annually based on risk assessment) • At least once in all children aged 3 to 5 years to detect amblyopia or its risk factors

Young adult and adult health screening and interventions

Service	Coverage
Abdominal aortic aneurysm; one-time screening	• Men ages 65–75 years who have ever smoked • Limited to one per lifetime
Blood pressure (hypertension) screening	• In adults 18 years and older with office blood pressure measurement

Cervical dysplasia	• 21 years
Cholesterol/lipid disorders and Statin use	• Use of a statin for the prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.
Colorectal cancer screening *Note: Single Source Brand Name Drugs (brand name drugs without a generic equivalent) and generic drugs are covered with no cost sharing for members age 45 to 75 years.*	• The following tests for all adults ages 45–75 years 1. High-sensitivity fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) annually or sDNA-FIT every 1 to 3 years 2. Flexible sigmoidoscopy every 5 years 3. Colonoscopy every 10 years 4. CT colonography every 5 years
Depression screening	• Screening for depression in the general adult population, including pregnant and postpartum women.
Diabetes screening: Prediabetes and Type 2 diabetes	• Asymptomatic adults ages 35–70 years who are overweight or obese • Includes: HbA1c screening, LDL-C screening and nephropathy screening
Fall prevention in older adults	• Exercise interventions for community-dwelling adults 65 years or older who are at increased risk for falls
Hepatitis B screening	• Adolescents and adults at increased risk of infection
Hepatitis C virus (HCV) infection screening	• Adults age 18–79 years
HIV screening	• Adolescents and adults age 15–65 years • Younger adolescents and older adults at increased risk of infection
HIV infection prevention: Preexposure prophylaxis (PrEP) *Note: This includes baseline and monitoring services associated with dispensing PrEP.*	• Clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
Lung cancer screening - Low-dose computed tomography	• Annual screening with low-dose computed tomography (LDCT) in adults age 50–80 who have a 20-pack per year smoking history, currently smoke or have quit smoking in the past 15 years.
Nutrition counseling	• Offer or refer adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.
Prevention of herpes zoster (shingles)	• Vaccination of people 50 years old and older
Sexually transmitted infection (STI) counseling	• All sexually active adolescents and adults who are at increased risk for sexually transmitted infections (STIs)
Skin cancer behavioral counseling	• Counseling all young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons age 6 months to 24 years with fair skin types to reduce their risk of skin cancer
Sudden Cardiac Arrest / Death	• Ages 17 to 21 based on risk assessment
Syphilis Infection: Screening	• All persons who are at increased risk for infection
Tobacco use/cessation interventions	• Clinicians are recommended to ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)—approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.
Tuberculin test	• Screening for latent tuberculosis infections in populations at increased risk.

Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions	• Screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Unhealthy drug use screening	• Screening by asking questions about unhealthy drug use in adults age 18 and older.
Weight loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions	• Offering or referring adults with body mass index (BMI) of 30 or higher (calculated in weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

Women's health screenings and intervention

Service	Coverage
Anxiety screening	• Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.
Bacteriuria screening	• Screening for asymptomatic bacteriuria using urine culture in pregnant persons.
BRCA-related cancer: Risk assessment, genetic counseling and genetic testing	• Women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool.
Breast cancer screening (mammogram) for average-risk women	• Biennial screening mammography for women aged 50 to 74 years • Average-risk women should initiate mammography screening no earlier than age 40 and no later than age 50. Screening mammography should occur at least biennially and as frequently as annually. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening. • Benefits of mammography screening are payable only if performed by a mammography-service doctor who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.
Breast cancer preventive medication	• Women at risk for breast cancer and at low risk for adverse medication effects
Breastfeeding promotion	• During pregnancy and after birth
Breastfeeding services and supplies	• Comprehensive lactation support services (including consultation and counseling, education by clinicians and peer support services and breastfeeding equipment and supplies) by a trained doctor during the antenatal, perinatal, pregnancy and/or in the postpartum periods to optimize the successful initiation and maintenance of breastfeeding. • Breastfeeding equipment and supplies include but are not limited to double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. • Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. • The costs for renting breastfeeding equipment are covered.

Cervical cancer and hrHPV: Screening	• Every 3 years in women aged 21 to 65 years, if not combined with high-risk human papillomavirus (hrHPV) testing • For women aged 30 to 65 years, cervical cytology every 5 years if combined with hrHPV testing.
Chlamydia screening	• All sexually active females age 24 and younger • Adult women age 25 and older who are at risk
Diabetes mellitus after pregnancy, screening	• Women with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with Type 2 diabetes mellitus should be screened for diabetes mellitus.
Domestic and Interpersonal violence screening and counseling	• Screening adolescents and women for interpersonal and domestic violence, at least annually, and, when needed, providing or referring for initial intervention services.
Female contraceptive methods and counseling	• All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered as prescribed by the member's participating doctor or OB/GYN. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period.)
Folic acid supplementation - A written or oral prescription must be provided by a provider and presented to a preferred pharmacy or preferred mail order pharmacy for coverage by the plan	• All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid
Gestational diabetes screening	• Pregnant persons at 24 weeks of pregnancy of gestation or after • Women with risk factors for diabetes mellitus should be screened for preexisting diabetes before 24 weeks of gestation – ideally at the first prenatal visit, based on current clinical best practices.
Gonorrhea screening	• All sexually active females age 24 and younger • Adult women age 25 and older who are at risk
Healthy weight and weight gain in pregnancy	• Offering pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy
Hepatitis B screening	• Pregnant women at their first prenatal visit
HIV screening	• All pregnant persons, including those who present in labor or at delivery whose HIV status is unknown • A screening test for HIV for all adolescent and adult women, age 15 and older, at least once during their lifetime. Earlier or additional screening should be based on risk. Rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. • Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk.
Obesity prevention in midlife women	• Counseling midlife women aged 40–60 years with normal or overweight body mass index (BMI) (18.5.29.9 kg/m^2) to maintain weight or limit weight gain to prevent obesity.

Osteoporosis screening	• Women at risk. May include but not limited to a DEXA scan (X-ray imaging test which measures bone density for osteoporosis). • Women 65 years and older. • Postmenopausal women younger than age 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
Perinatal depression	• Clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depressions to counseling interventions
Preeclampsia prevention: aspirin	• Low-dose (81 mg/d) for pregnant people, after 12 weeks gestation, who are at high risk
Preeclampsia screening	• Blood pressure measurements throughout pregnancy
Rh incompatibility test - Rh (D) blood typing and antibody testing	• Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care • Repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 week's gestation, unless the biological father is known to be Rh(D)-negative.
Sexually transmitted infections (STIs), counseling	• Directed behavioral counseling for sexually active adolescent and adult women at an increased risk for STIs. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment.
Syphilis screening	• Early screening for syphilis infection in all pregnant women
Tobacco use/cessation interventions	• Clinicians are recommended to ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco
Urinary incontinence screening	• Screening women for urinary incontinence annually.
Well-woman preventive visits	• At least one preventive care visit per year beginning in adolescence and continuing across the lifespan. • These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status and risk factors. • Well-woman visits also include prepregnancy, prenatal, postpartum and interpregnancy visits.

Many of these preventive services are covered with no member cost sharing when obtained from a participating/preferred doctor, unless otherwise noted. If your doctor provides medical services during your preventive care visit that are not included in the preventive care list, these items will be considered under your standard medical plan coverage. This means you may be responsible for cost sharing. See your plan materials for specific details about your plan coverage.

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

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule

of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Health Resources and Services (HRSA) supported Women's Preventive Services Guidelines and are subject to change by these organizations. For the most current list of preventive Covered Services please refer to: **https://www.healthcare.gov/what-are-my-preventive-care-benefits.** For additional information on immunizations, visit the immunization schedule section of **cdc.gov.**

Geisinger Health Plan may refer collectively to healthcare coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated healthcare delivery and coverage organization.

626075 Preventative services health coverage. 10.2022 DW