Amendment to Non-Grandfathered Group Benefit Document

GEISINGER CHOICE PPO WITH NO REFERRAL QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN ("QHDHP")

Identified as the

GEISINGER ALL-ACCESS QHDHP PPO

GEISINGER QUALITY OPTIONS, INC.
A Pennsylvania corporation located at:
100 North Academy Avenue
Danville, Pennsylvania 17822

GEISINGER QUALITY OPTIONS, INC.
A Pennsylvania corporation located at:
100 North Academy Avenue
Danville, Pennsylvania 17822

Dear Subscriber:

Thank you for choosing a Geisinger All-Access QHDHP PPO product. This document amends your Subscription Certificate by adding, deleting and revising certain provisions. It would be advisable to reference your Subscription Certificate as you review the revisions detailed in this Amendment as the changes affect the benefits provided to you in your Subscription Certificate. Some of the benefits in this Amendment are those set forth in the Patient Protection and Affordable Care Act ("PPACA") of 2010 (commonly known as Health Care Reform). However, this Amendment also contains other non-PPACA changes to your benefit documents.

Please keep this Amendment handy for easy reference. If you have any questions about the Amendment revisions, our Customer Service Team will be happy to help. Call them at the number listed on the back of your Member Identification Card.

Sincerely,

Kurt J. Wrobel
President

100 North Academy Avenue • Danville, PA 17822-3226

Discrimination is against the law

Geisinger Quality Options, Inc. 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 Quality Options, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Quality Options, Inc.:

- 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 Quality Options, Inc. at 800-447-4000 or TTY: 711.

If you believe that Geisinger Quality Options, Inc. 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 الصم والبكم: 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).

સુચના: 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 គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

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

HPM 50 alb: Nondiscrimination dev. 9.12.16
Y0032_16242_2 File and Use 9/2/16

GEISINGER QUALITY OPTIONS, INC.

AMENDMENT TO THE

QHDHP PPO
GROUP SUBSCRIPTION CERTIFICATE

The **GEISINGER QUALITY OPTIONS INC., PPO GROUP SUBSCRIPTION CERTIFICATE ("Certificate") (Form M-151-444-F Rev. 4/10)** to which this Amendment is attached, is revised as follows**:**

1. **MARKETING NAME OF CERTIFICATE –** The marketing name of this Certificate shall hereby be revised from "Geisinger Choice PPO with No Referral Qualified High Deductible Health Plan" to "Geisinger All-Access QHDHP PPO".

All references to the Certificate's marketing name which may appear in the Certificate, Amendments, the Schedule of Benefits, the enrollment applications and the Member's Enrollment Letter are hereby correspondingly revised.

2. **SECTION 1. DEFINITIONS.**

A. Section **1.5, Benefit Period,** is deleted in its entirety and replaced with the following:

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.

B. Section **1.13**, the definition of "**Creditable Coverage",** and all references to "Creditable Coverage" are deleted from the Certificate.

C. Section **1.18,** the definition of **Designated Behavioral Health Benefit Program,** and all references to "Designated Behavioral Health Benefit Program" are deleted from the Certificate.

D. Section **1.24, Experimental, Investigational or Unproven Services**, Subsection "b" is deleted in its entirety and replaced with the following:

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

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

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

F. Section **1.31, Health Insurance Portability and Accountability Act of 1996 (HIPAA),** is deleted in its entirety and replaced with the following:

1.31 **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.

G. **Section 1.32.3, Hospice,** is deleted in its entirety and replaced with the following:

1.32.3 **Hospice** means a Covered Service rendered by a 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.

H. Section **1.42, Member,** is deleted in its entirety and replaced with the following:

1.42 **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).

I. The definition of **Precertification**, (**Section 1.48**), is deleted from the Certificate and replaced with the following:

1.48 **Precertification** means the process detailed in Section 2.3.1 of this Certificate whereby all non-emergency inpatient hospital admissions or certain designated procedures and services as listed in Exhibit 3, Precertification List, are reviewed by the PPO for coverage determination based on Medical Necessity prior to the provision of services.

J. The definition of **Pre-Existing Condition**, (**Section 1.49**), is deleted from the Certificate.

K. Section **1.66, Urgent Care**, is deleted in its entirety and replaced with the following:

1.66 **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.

L. The definition, **Mini-COBRA,** is added to the Certificate as follows:

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

M. The definition, **Provider,** is added to the Certificate as follows:

Provider shall mean Health Care Provider.

N. The definition**, Maximum Out-of-Pocket,** is added to the Certificate as follows:

Maximum Out-of-Pocket means the maximum dollar amount that a Member 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 includes the Coinsurance Maximum, (as applicable). 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;
(ii) amounts above the PPO's Non-Preferred Provider Fee Schedule Amount;
(iii) amounts for non-Covered Services; and
(iv) amounts for Covered Services obtained from a Non-Preferred Provider (as applicable).

This means that the Subscriber or Member, not the PPO, will be responsible for payment of all the amounts noted above, even if the Maximum Out-of-Pocket has been reached. As item (ii) can result in substantial financial responsibility for the Subscriber or Member, please refer to Exhibit 2 of this Certificate for an illustration of potential Cost Sharing when Non-Preferred Providers are utilized. Please note that, as applicable, there are separate Maximum Out-of-Pocket amounts for Preferred and Non-Preferred Providers. Maximum Out-of-Pocket amounts paid for Covered Services provided by either a Preferred Provider or a Non-Preferred Provider do not accrue towards each other. 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.

O. The definition, **Telehealth,** is added to the Certificate as follows:

Telehealth means remote clinical services <u>and</u> remote non-clinical services.

3. SECTION 2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS.

A. Section **2.1, Medical Management Procedures,** is deleted from the Certificate and replaced with the following:

2.1 Medical Management Procedures. The following is a description of the PPO's Medical Management Procedures.

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

b) Planned inpatient admissions and certain designated services and procedures require Precertification.

c) The PPO'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 PPO'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 PPO is not the primary payor), home health care and outpatient rehabilitation. Concurrent review is the responsibility of the facility, not the Member.

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

g) The PPO'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 PPO to be: (i) Medically Necessary; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available. The PPO'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.

B. Section **2.2, Precertification**, is deleted from the Certificate and replaced with the following:

2.2 Precertification. The purpose of Precertification is to determine Medical Necessity and to encourage and facilitate the use of the most appropriate level of care utilizing objective and evidence-based criteria taking individual circumstances and the local delivery system into account. In the absence of criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations. Alternate treatment settings may be recommended for approved procedures if inpatient hospitalization is deemed unnecessary. Precertification does not verify a Member's coverage by the PPO or guarantee payment. Precertification is required even when the PPO is not the primary carrier.

C. Section **2.3, Designated Procedures and Services Requiring Precertification,** is deleted from the Certificate and replaced with the following:

2.3 Designated Procedures and Services Requiring Precertification. All non-emergency inpatient hospital admissions as well as certain designated procedures and services **REQUIRE** Precertification. Precertification is required for such services regardless of whether they are performed in an inpatient or outpatient setting.

Please refer to **Exhibit 3** of this Certificate for a list of services, supplies, agents/medications which require Precertification.

4. SECTION 3. COVERED SERVICES.

A. Section **3.1.1**, **Covered Services from a Non-Preferred Provider,** Subsection **3.1.1 (c)** is deleted from the Certificate and replaced with the following:

c) when Covered Services are not available from a Preferred Provider; or

B. Section **3.1.3, Covered Service Location Cost Sharing,** is deleted from the Certificate and replaced with the following:

3.1.3 Covered Service Location Cost Sharing. Certain benefits (as indicated on the Member's Schedule of Benefits) will subject the Member to a 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.

C. **Section 3.2, Cardiac Rehabilitation,** is deleted from the Certificate and replaced with the following:

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

D. Section **3.3.4**, **Outpatient Training and Education,** the introductory paragraph is amended as follows:

"Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered when provided under the supervision of a Preferred Provider with expertise in diabetes to ensure

that Members with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. This shall include visits:"

Sections i, ii, iii and 3.3.4.1, **Cost-Sharing**, shall remain as written in the Certificate.

E. Section **3.3.5, Diabetic Eye Examinations**, is added to the Certificate as follows:

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

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

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

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

d) **Rehabilitative Devices** are devices which meet the needs of individuals with disabilities and address the barriers confronted by such individuals. Rehabilitative Devices may address needs in the areas of education, rehabilitation, employment, transportation, and independent living. Rehabilitative Devices include only those devices or services required to overcome the functional limitations imposed by an individual's disability. Examples of Rehabilitative Devices include but are not limited to a speaking board or other communication device for a Member who cannot speak and self-care/home management training such as ADL (Activities of Daily Living) and compensatory training/instructions in the use of adaptive equipment.

Rehabilitative Devices do not include:

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

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

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

3.6.4 **Prosthetic Devices**. The PPO will pay for the purchase of one (1) Prosthetic Device or the replacement of component parts or modification of an existing Prosthetic Device every five (5) years when obtained from a Preferred Provider subject to the Exclusions set forth in Section 4.59.21 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.

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

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

G. **Section 3.7.3, Emergency Services Protocol, Cost Sharing,** is deleted from the Certificate and replaced with the following:

3.7.3 **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.

H. Section **3.8, Enteral Feeding/Food Supplements,** is deleted from the Certificate in its entirety and replaced with the following:

3.8 **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 Preferred Provider. Upon Precertification, 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 Precertification, 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.

I. Section **3.10, Home Health Care.** Precertification is no longer required for home health care Covered Services as described in Sections 3.10; 3.10.1; 3.10.2 and 3.10.3 and reference thereto is hereby deleted.

J. Sections **3.11, Hospice, 3.11.1, Hospice Benefit Election,** and **3.11.2, Limitations**, are deleted from the Certificate and replaced with the following:

3.11 **Hospice.** The following services for Hospice are covered: Routine Home Care, Continuous Care, General Inpatient Care, and Respite Care, as well as those Hospice services noted in this Certificate, provided such care is directly related to the Terminal Illness of a Member and rendered in accordance with the Member's Plan of Care.

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

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

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

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

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

K. Section **3.13, Implanted Devices,** is deleted from the Certificate and replaced with the following:

3.13 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.

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

L. **Section 3.14, Mastectomy and Breast Cancer Reconstructive Surgery,** is deleted from the Certificate in its entirety and replaced with the following:

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

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

M. Section **3.15**, **Maternity Care,** is deleted from the Certificate in its entirety and replaced with the following:

3.15 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special

procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the Provider. Certified licensed nurse midwife Provider services shall be covered only if provided in a hospital Provider or an appropriately licensed free-standing birthing center Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.18 of this Certificate.

3.15.1 **Cost Sharing.** The office visit Copayment or Coinsurance 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 or Coinsurance 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, Deductible or Coinsurance amounts under this Section.

3.15.2 **Childbirth Preparedness Classes.** Childbirth preparedness classes for education focused on preparing for labor and the birth of a child are covered for pregnant female Members up to a $100 limit per Benefit Period. Such classes are intended to prepare female Members for childbirth and may not be related solely to child rearing. Classes may be provided by a Preferred or Non-Preferred Provider. In order to be reimbursed by the PPO for a childbirth preparedness class, the Member must follow the requirements of Section 8.14, of the Certificate. However, the Member is **not required** to follow the claim form requirements set forth in Section 8.14.1 of the Certificate; instead, the Member should submit a copy of the childbirth preparedness class receipt indicating the payment amount and the completion date of the class.

N. Section **3.16, Mental Health and Substance Abuse Services,** is deleted from the Certificate and replaced with the following:

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

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

3.16.1.1 **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.

3.16.1.2 **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.

3.16.2 **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 upon Precertification. Mental Health Inpatient Services obtained from a behavioral health Preferred Provider are subject to the Preferred Provider "Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Mental Health Services obtained from a Non-Preferred Provider are subject to the Non-Preferred Provider "Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

3.16.2.1 **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 behavioral health Preferred Provider who participates in the Designated Behavioral Health Benefit Program are subject to the Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing as set forth on the Schedule of Benefits. Partial hospitalization services obtained from a Non-Preferred Provider are subject to Precertification and are subject to the Non-Preferred Provider "Serious Mental Illness Partial hospital Services" Cost Sharing set forth on the Schedule of Benefits.

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

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

3.16.4 **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 upon Precertification. Non-Serious Mental Illness Inpatient Services obtained from a behavioral health Preferred Provider are subject to the Preferred Provider "Non-Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Non-Serious Mental Illness Services obtained from a Non-Preferred Provider are subject to Precertification and are subject to the Non-Preferred Provider "Non-Serious Mental Illness Inpatient facility Services and Inpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

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

3.16.5 **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 upon Precertification, for either individual or group therapy (combined) per Benefit Period. Outpatient Professional Mental Health Services obtained from a behavioral health Preferred Provider are subject to the Preferred Provider "Outpatient Professional Services" Cost Sharing as set forth on the Schedule of Benefits. Mental Health Services obtained from a Non-Preferred Provider are subject to the Non-Preferred Provider "Outpatient Professional Services" Cost Sharing set forth on the Schedule of Benefits.

O. Section **3.17, Mental Health and Substance Abuse Services,** is deleted from the Certificate in its entirety and restated in Section 3.16.

P. Section **3.18, Newborn Coverage** is deleted from the Certificate and replaced with the following:

3.18 **Newborn Coverage.** Newborn children are covered as Members from birth for the first thirty-one (31) days of life. Such coverage shall include Medically Necessary care for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Section 6.2.3.

Q. Section **3.19**, **Oral Surgery**, is amended to delete subsection **3.19.5, Deep Sedation or General Anesthesia and Related Professional Services** and replace it with the following and subsection **3.19.6, Cost Sharing**, is added to the Certificate:

3.19.5 **General Anesthesia and Associated Medical Costs** provided in connection with an inpatient or outpatient oral surgery procedure are covered as set forth in Section 3.35 of this Certificate.

3.19.6 **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".

R. Section **3.20, Ostomy Supplies,** is deleted from the Certificate and replaced with the following:

3.20 **Ostomy Supplies.** The PPO will cover ostomy supplies and maintenance supplies (including but not limited to barrier wipes, pastes and tape), provided by a Preferred 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).

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

3.22 **Preventive Services.** The following preventive health care services are covered:

3.22.1 **Periodic health assessments** including:

a) physical examination (s).

3.22.1.1 **Periodic Health Assessment Cost Sharing.** For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.22.1, above, refer to the Schedule of Benefits under "PHYSICIAN OFFICE SERVICES". The Cost Sharing associated with these Covered Services will differ depending upon whether the services were provided by a Primary Care Physician or a Specialist.

3.22.2 **Additional Preventive Services listed in <u>Exhibit 4</u>.** The preventive services listed in **<u>Exhibit 4</u>** are not subject to Cost Sharing only when obtained from a Preferred Provider. Preventive services listed in **<u>Exhibit 4</u>** obtained from a Non-Preferred Provider are not covered. For the Cost Sharing applicable to these preventive services, refer to the Schedule of Benefits under "PREVENTIVE SERVICES".

T. Section **3.23, Pulmonary Rehabilitation,** is deleted from the Certificate and replaced with the following:

3.23 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered subject to the Benefit Limit and Cost Sharing set forth on the Schedule of Benefits.

U. Section **3.24, Rehabilitative Services,** is deleted from the Certificate and replaced with the following:

3.24 Rehabilitative Services.

3.24.1 **Physical and Occupational Therapy Services**. Physical and occupational therapy, on either an outpatient or inpatient basis, is covered; however, Precertification is required for outpatient/inpatient rehabilitative facility services provided by Non-Preferred Providers.

3.24.1.1 **Physical Therapy for Back/Neck-Related Pain**. Upon Precertification, 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 (10th) visit is also noted on the Schedule of Benefits.

3.24.2 **Speech Therapy Services**. Speech therapy, on either an outpatient or inpatient basis is covered; however, Precertification is required for outpatient/inpatient rehabilitative facility services provided by Non-Preferred Providers.

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

3.26 Select Injectable Drugs. Subject to the terms and conditions set forth in this Certificate, the following injectable drugs are a Covered Service when provided by a Preferred 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

3.26.1 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 Preferred Provider(s).

X. **Section 3.29.2, Precertification,** is deleted from the Certificate and replaced with the following:

3.29.2 Precertification. All transplant surgery and transplant-related services (with the exception of corneal transplants) require Precertification by the PPO. Medical criteria for any approved transplants will be applied and each potential transplant must be appropriate for the medical condition for which the transplant is proposed. Corneal transplants do not require Precertification and are covered when Medically Necessary and performed through a Preferred Provider.

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

Z. **Section 3.29.8, Travel, Lodging and Meal Expense Reimbursement,** is deleted from the Certificate and replaced with the following:

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

AA. **Section 3.30.2, Scheduled Services,** is deleted from the Certificate and replaced with the following:

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

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

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

CC. **Section 3.33, Voluntary Family Planning Services,** is deleted from the Certificate and replaced with the following:

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

a) professional services 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 4.17 and 4.28).

DD. Section **3.35, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**, is added to the Certificate as follows:

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

3.35.1 **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.

3.35.2 **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.

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

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

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

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

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

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

3.35.4 **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".

EE. Section 3.36, Infusion Therapy, is added to the Certificate as follows:

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

FF. Section 3.37, Injectable Drugs, is added to the Certificate as follows:

3.37 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 3.26.

GG. Section 3.38, Spinal Injections, is added to the Certificate as follows:

3.38 **Spinal Injections.** Upon Precertification, 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.

HH. **Section 3.39, Substance Abuse**, is added to the Certificate as follows:

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

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

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

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

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

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

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

3.39.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered upon Precertification. Services obtained from a behavioral health Preferred Provider are subject to the Preferred Provider "Non-Hospital Residential Rehabilitation Services" Cost Sharing as set forth on the Schedule of Benefits. Non-Hospital Residential Rehabilitation Services obtained from a Non-Preferred Provider are subject to the Non-Preferred Provider "Non-Hospital Residential Rehabilitation Services" Cost Sharing set forth on the Schedule of Benefits. The following inpatient non-hospital residential care services are covered when administered by an employee of the

facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

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

3.39.4.3 **Partial Hospitalization.** Upon Precertification, Provider's may authorize partial hospitalization services for Substance Abuse rehabilitation each Benefit Period.

II. Section 3.40, Gender Transition Services, is added to the Certificate as follows:

3.40 Gender Transition Services. Upon Precertification, 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.

JJ. Section 3.41, Impacted Wisdom Teeth, is added to the Certificate as follows:

3.41 Impacted Wisdom Teeth. Subject to Section 3.41.1 below, Cost Sharing set forth on the Schedule of Benefits and applicable Exclusions set forth in Section 4, the PPO will cover consultation and services related to the extraction of partially or totally bony third molars when performed by a Preferred Provider.

3.41.1 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 **3.35, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**. Such coverage must be authorized in advance by the PPO.

KK. Section 3.42, Refractions, is added to the Certificate as follows:

3.42 Refractions. An examination to determine the refractive error of the eye is covered if provided by a Preferred 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.

LL. Section 3.43, Chemotherapy Medications, is added to the Certificate as follows:

3.43 Chemotherapy Medications.

Upon Precertification, the PPO 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.

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.

MM. Section **3.44, Hepatitis C – Center of Excellence**, is added to the Certificate as follows:

3.44 Hepatitis C – Center of Excellence

3.44.1 **Definition.** For purposes of this Section 3. 44, Center of Excellence ("COE") shall mean a Preferred Health Care Provider designated by the PPO. 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.

3.44.2 **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 Preferred 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 Preferred Provider of the COE, the PPO 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 Preferred 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.

NN. Section **3.45, Amyloidosis– Center of Excellence**, is added to the Certificate as follows:

3.45 Amyloidosis – Center of Excellence

3.45.1 **Definition.** For purposes of this Section 3.45, Center of Excellence ("COE") shall mean a Preferred Health Care Provider designated by the PPO. 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.

3.45.2 **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 Preferred 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 Preferred Provider of the COE, the PPO 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 Preferred 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.

4. SECTION 4. EXCLUSIONS.

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

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

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

B. Section **4.6, Biofeedback**, is deleted from the Certificate. Biofeedback is now referenced in Section **4.1**, **Alternative Therapies**, as a type of alternative therapy that is not covered.

C. Section **4.7, Blood or Other Body Tissue and Fluids, Including Storage**, is deleted from the Certificate and replaced with the following:

4.7 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**.

D. Section **4.8, Breast Surgery**, is deleted from the Certificate and replaced, as follows:

4.8 Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 of this Certificate.

E. Section **4.10, Complications Resulting from a Non-Covered Procedure or Service,** is deleted from the Certificate.

F. Section **4.12**, **Cosmetic Surgery,** is deleted from the Certificate and replaced with the following:

4.12 Cosmetic Surgery. Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO, is **NOT COVERED**, except as provided in Sections 3.14, 3.25.1 or 3.25.2 of this Certificate.

G. Section **4.14, Dentistry**, is deleted from the Certificate in its entirety and replaced as follows:

4.14 Dentistry. The PPO does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, 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 PPO will cover: a) expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.19.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth), b) General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.35 and c) Impacted Wisdom Teeth as set forth in Certificate Section 3.41.

H. Section **4.15, Drug Maintenance Programs** is deleted from the Certificate.

I. Section **4.16**, **Drugs,** is deleted from the Certificate and replaced with the following:

4.16 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in Certificate Sections 3.3.3, 3.29.7 or as set forth in **Exhibit 4, 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.

J. Section **4.17, Drugs and Devices for Purposes of Contraception,** is deleted from the Certificate in its entirety and replaced with the following:

4.17 Drugs and Devices for Purposes of Contraception. Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of **Exhibit 4, Preventive Services** and the **Outpatient Prescription Drugs Rider** if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.

K. Section 4.18, Elective Abortions, is deleted in its entirety and replaced with the following:

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

L. Section **4.20, Failure to Obtain Precertification,** is deleted from the Certificate and replaced with the following:

4.20 Failure to Obtain Precertification. The following services are **NOT COVERED** when they are obtained from a Non-Preferred Provider prior to Precertification by the PPO:

4.20.1 All non-emergency inpatient hospital admissions; and

4.20.2 the procedures and services set forth in **Exhibit 3, Precertification List,** of this Certificate.

M. Section 4.22, Gender Reassignment, is deleted from the Certificate.

N. Section **4.45**, **Private Duty Nursing,** is deleted from the Certificate and replaced with the following:

4.45 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.

O. Section 4.46, Refraction Examinations, is deleted from the Certificate and replaced with the following:

4.46 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.

iii) Refraction services that are not obtained from Preferred Providers.

P. Section **4.52, Services Provided by a Member's Relative or Self,** is deleted from the Certificate and replaced with the following:

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**.

Q. Section **4.53**, **Services Related to or Required by a Non-Covered Service,** is deleted from the Certificate**.**

R. Section **4.55, Transportation Services,** is deleted from the Certificate and replaced with the following:

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

S. Section **4.57**, **Weight Control,** is deleted from the Certificate and replaced with the following:

4.57 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.34 of this Certificate or as set forth in **Exhibit 4**, **Preventive Services.**

T. Section **4.58.2, Enteral Feedings/Food Supplements,** shall be deleted in its entirety and replaced with the following:

4.58.2 Medical Foods. Enteral feedings/food supplements and amino acid-based elemental medical formula obtained from Non-Preferred Providers are **NOT COVERED.**

U. Section **4.58.5, Mental Health or Substance Abuse Services Obtained From a Provider Who Does Not Participate in the PPO's Designated Behavioral Health Benefit Program,** is deleted from the Certificate in its entirety.

V. Section **4.58.9, Ostomy Supplies,** is added to the Certificate as follows:

4.58.9 Ostomy Supplies. Ostomy supplies obtained from Non-Preferred Providers are **NOT COVERED**.

W. Section **4.58.10, Scheduled Transportation Services,** is added to the Certificate as follows:

4.58.10 Scheduled Transportation Services. Scheduled transportation services obtained from Non-Preferred Providers are **NOT COVERED**.

X. Section **4.58.11, Urological Supplies,** is added to the Certificate as follows:

4.58.11 Urological Supplies. Urological supplies obtained from Non-Preferred Providers are **NOT COVERED**.

Y. Section **4.58.12, Impacted Wisdom Teeth Services**, is added to the Certificate as follows:

4.58.12 Impacted Wisdom Teeth Services. Impacted wisdom teeth services that are not obtained from Preferred Providers are **NOT COVERED.**

Z. Section **4.58.13, Refraction Services,** is added to the Certificate as follows:

4.58.13 Refraction Services. Refraction services that are not obtained from Preferred Providers are **NOT COVERED.**

AA. Section **4.59.6 Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** is
deleted from the Certificate and replaced with the following:

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

BB. Section **4.59.11, Home Monitoring Equipment**, is deleted from the Certificate.

CC. Section **4.59.19**, **Non-Standard Equipment or Devices**, is deleted from the Certificate and replaced
with the following:

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

DD. Subsection **4.59.21, "Replacement of Component Parts or Modification …"** is deleted from the Certificate and replaced with the following:

4.59.21 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 3.6.4 and 3.6.4.1 of this Certificate.

EE. Section **4.59.22, Specifically Listed Items, Devices and Equipment**, is amended to delete reference to:

a) Breast pumps.

FF. Section **4.60, Oral Nutrition Products or Supplements** is added to the Certificate as follows:

4.60 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.

GG. Section **4.61, Personal and Athletic Trainer Services** is added to the Certificate as follows**:**

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

HH. Section **4.62**, **Services Provided in Conjunction with a Non-Covered Service** is added to the Certificate as follows**:**

4.62 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 3.33.

II. Section **4.63, General Anesthesia for Temporal Mandibular Joint Disorders (TMJ),** is added to the Certificate as follows:

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

JJ. The following sections are deleted from Section 4 of the Certificate in their entirety:

(a) Section 4.32, Mental Health Inpatient Professional Services;
(b) Section 4.33, Mental Health Inpatient Services; and
(c) Section 4.34, Mental Health Partial Hospitalization Services.

KK. Section **4.19**, **Experimental, Investigational or Unproven Services**, is deleted from the Certificate and replaced with the following:

4.19 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.

LL. Section **4.64, Surrogate Services**, is added to the Certificate as follows:

4.64 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.**

MM. Section 4.65, Reversal of Genital Surgery, is added to the Certificate as follows:

4.65 Reversal of Genital Surgery. Surgical procedures to reverse genital surgery are **NOT COVERED**, except as stipulated in Section 4.62, **Services Provided in Conjunction with a Non-Covered Service**.

NN. Section 4.66, Reversal of Surgery to Revise Secondary Sex Characteristics, is added to the Certificate as follows:

4.66 Reversal of Surgery to Revise Secondary Sex Characteristics. Surgical procedures to reverse secondary sex characteristic surgery are **NOT COVERED**, except as stipulated in Section 4.62, **Services Provided in Conjunction with a Non-Covered Service**.

OO. Section **4.11, Corrective Devices,** is deleted from the Certificate and replaced with the following:

4.11 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 3.6.4 Prosthetic Devices, Section 3.13 Implanted Devices, and under the terms of the following Rider: Eyewear.

PP. Section **4.5, Behavioral Services,** is deleted from the Certificate and replaced with the following:

4.5 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 such Rider will determine the behavioral services available for the Member.

QQ. Section 4.69 is added to the Certificate as follows:

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

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

6. SECTION 5. APPEAL PROCEDURE.

A. **SECTION 5, APPEAL PROCEDURE**, is deleted from the Certificate and replaced with the following new **SECTION 5**, **APPEAL PROCEDURE**:

SECTION 5. APPEAL PROCEDURE

APPEAL PROCEDURE. Requests for an appeal must be submitted **in writing** and received by the PPO within **one hundred eighty (180) days** following the Member's receipt of the notification of an Adverse Benefit Determination (an Adverse Benefit Determination is any decision made by the PPO with respect to payment or service related issues that results in a denial).

If a Member chooses to appeal an Adverse Benefit Determination, a ***written request*** *must be submitted to:*

Geisinger PPO
Appeal Department
100 North Academy Avenue
Danville, PA 17822-3220

At any time during any of the appeal processes outlined below, a Member may choose to designate in writing a representative to participate in the appeal process on the Member's behalf (an "Authorized Representative"). In this Section 5 of the Certificate, the definition of Member shall include a Member's Authorized Representative. The Member shall be responsible to notify the PPO in writing of such designation. The PPO has an authorization form available for the Member's use in order to designate an individual to act as the Member's Authorized Representative. 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.

Members have the right to provide the PPO with written comments, documents, records or other information to be considered as part of the appeal review.

A Member may call the PPO's toll-free telephone number located on the back of the Member's Identification Card, Monday through Friday from 8:00 a.m. through 6:00 p.m. to obtain information regarding the filing and status of an appeal.

When a Member submits a written request for an appeal, the PPO will complete a full and fair review and provide written notification of the PPO's decision to the Member within the following time frames:

Pre-Service Appeal – Not later than 30 days after the PPO receives the written request
Post-Service Appeal – Not later than 30 days after the PPO receives the written request
Urgent Care Appeal – Not later than 72 hours after the PPO receives the request

5.1 Pre-Service Appeal Procedure. A Pre-Service Appeal is a request to change an Adverse Benefit Determination for care or services that the PPO must approve, in whole or in part, in advance of the Member obtaining care or services.

A Member may request a Pre-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

5.1.1 **Pre-Service Appeal Review for Denials not based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical

judgment will be reviewed by the 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 PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the PPO. The PPO 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 **Pre-Service Appeal Review for Denial Based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The 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. The 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. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the PPO shall provide the Member or the Health Care Provider 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 appeal. The Member and/or the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The PPO and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The PPO shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review meeting.

5.1.3 **Pre-Service Appeal Time Frame for Decision.** A Pre-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the Member's written request. The PPO shall provide the Member with a written notification of the PPO's decision no later than thirty (30) days from receipt. The written notification from the PPO will include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;

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

e) the Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.2 Post-Service Appeal Procedure. A Post-Service Appeal is a request to change an Adverse Benefit Determination for care or services that have already been received by the Member. A Member may request a Post-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

5.2.1 **Post-Service Appeal Review for Denials not based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the 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 PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the PPO. The PPO 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.

5.2.2 **Post-Service Appeal for Denials based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The 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. The 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. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the PPO shall provide the Member or the Health Care Provider 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 appeal. The Member and the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The PPO and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The PPO shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review Committee meeting.

5.2.3 **Post-Service Appeal Time Frame for Decision.** A Post-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the written request. The PPO shall provide the Member with written notification of the PPO's decision no later than thirty (30) days from receipt. The written notification from the PPO shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;

d) notification that the Member may request assistance with their appeal from the applicable state's Office of Health Insurance Consumer Assistance; and

e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.3 Urgent Care Appeal Procedure. A claim involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

a) could seriously jeopardize the life or health of the Member, or the ability of the Member to regain maximum function as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or

b) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

5.3.1 **Request of an Urgent Care Appeal**. A Member or a Member's Health Care Provider may request an Urgent Care Appeal either orally or in writing. The Member or the Member's Health Care Provider requesting the Urgent Care Appeal may contact the PPO by telephone, fax or other methods that will expedite receipt of the information by the PPO. The PPO will contact the requestor by telephone, fax or other prompt method to resolve the Member's appeal. The PPO will provide a full and fair review of the appeal.

5.3.2 **Review of an Urgent Care Appeal.** The PPO shall perform an Urgent Care Appeal Review and render a decision within seventy two (72) hours of receipt of the Member's request. The Member shall be responsible to provide information to the PPO in an expedited manner to allow the PPO to conform to the Urgent Care Appeal requirements. The Urgent Care 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 Urgent Care Appeal 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. The PPO shall provide the Member with written notification of the PPO's decision that shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific PPO provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and

d) notification that the Member may request assistance with their Appeal from the applicable state's Office of Health Insurance Consumer Assistance; and

e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

5.4 External Appeal Review Procedure. If the Member is not satisfied with the Final Adverse Benefit Determination (a Final Adverse Benefit Determination is the decision made by the PPO in regard to an appeal filed in accordance with Sections 5.1, 5.2 or 5.3 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 Appeal 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 PPO 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 PPO must complete a preliminary review of the request to determine whether:

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

b) The adverse benefit determination 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 PPO (e.g., worker classification or similar determination);

c) The Member has exhausted the PPO's internal appeal 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 PPO 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 5.4.2) 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 PPO 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 PPO'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 PPO, Member, or the Member's treating Provider;

d) The terms of the Member's PPO plan to ensure that the IRO's decision is not contrary to the terms of the PPO 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 PPO unless the criteria are inconsistent with the terms of the PPO plan or with applicable law; and

g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section 5.4.2.2 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 PPO 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 PPO 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 PPO 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 PPO must provide any benefits (including making payment on the claim) pursuant to the final external review

decision without delay, regardless of whether the PPO intends to seek judicial review of the external decision and unless or until there is a judicial decision.

5.4.3 **Expedited External Review Procedure.** The Member may make a request for an expedited external review at the time the Member receives:

(a) an Adverse Benefit Determination if the Determination involves a medical condition of the Member for which the timeframe for an internal urgent care appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function **and** the Member has filed a request for an internal urgent care appeal; or

(b) a final internal urgent care appeal if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final internal urgent care appeal concerns an admission, availability of care, continued stay or health care item or service for which the Member received emergency services but has not been discharged from a facility.

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

5.4.3.1 **Preliminary Review**. If the PPO determines the expedited external review request meets the requirements set forth in section 5.4.2.1, 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.

5.4.3.2 **External Review Procedure**. If an external review is warranted, the PPO will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The PPO 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 5.4.2.2. 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 PPO's internal appeal procedures.

5.4.3.3 **Notice of the Final External Review Decision.** The IRO will provide notice of the final external review decision in accordance with section 5.4.2.3 (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 PPO.

7. SECTION 6 - ELIGIBILITY.

A. Sections **6.2 through 6.2.6** are deleted from the Certificate and replaced with the following:

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

a) The spouse of a Subscriber under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania.

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 PPO 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 placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Such children 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 is duly paid.

6.2.1 Intentionally left blank.

6.2.2 New Spouse. A newly married Subscriber may arrange for Family Coverage by enrolling his or her spouse in the PPO 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. No Evidence of Insurability shall be required.

6.2.3 Newborn Child(ren).

6.2.3.1 **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.

6.2.3.2 **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 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.

6.2.3.3 **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.

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

6.2.5 Intentionally left blank.

6.2.6 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 PPO 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 PPO of the child's incapacity and dependency within sixty (60) days of the date the child's coverage would otherwise terminate. The PPO 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 PPO is first notified of such disability and dependency, whichever is earlier.

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

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

A full-time student under this Section shall mean

(i) a dependent child who is eligible for health insurance coverage under their parents' insurance policy, **and**

(ii) who is either a high school student or 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 PPO may periodically require documentary proof of enrollment as a student upon reaching the Maximum Age for dependent children set forth on the Schedule of Benefits, or upon the date on which the PPO is first notified of such enrollment.

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

E. Section **6.2.8, Noncustodial Children,** is deleted from the Certificate and replaced with the following:

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

(a) The PPO 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 PPO for membership of such child.

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

(c) The <u>effective date of membership</u> in the PPO for a noncustodial child will be determined as follows:

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

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

(d) The Subscriber shall notify the PPO of the name and address of the custodial parent in order to allow the PPO 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 PPO may not disenroll or eliminate coverage of any child unless the PPO 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.

F. Section **6.6.2 Non-Open Enrollment Period Application** is deleted from the Certificate and replaced with the following:

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 date 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.

G. Section 6.7 Manner of Enrollment is deleted from the Certificate and replaced with the following:

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.

H. Section 6.8 Failure to Enroll Or Be Enrolled When Eligible is deleted from the Certificate and replaced with the following:

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.

I. Section **6.8.1, Special Enrollment Period – Loss of Eligibility Status**, is deleted from the Certificate and replaced with the following:

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 PPO (subject to PPO eligibility rules) if (i) the individual and their dependents are otherwise eligible to enroll in the benefit package; (ii) when coverage under the PPO 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 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 PPO (subject to PPO 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 PPO.

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

K. Section **6.12, Notice of Ineligibility,** shall be deleted from the Certification and replaced with the following:

6.12 Notice of Ineligibility. It shall be the Subscriber's responsibility to notify the Group or the PPO 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.

8. SECTION 7 – PAYMENT PROVISIONS.

A. Section **7.2.1** is added to the Certificate as follows:

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

B. Section **7.4, Grace Period,** shall be deleted from the Certificate and replaced with the following:

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 8.6 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 8.9. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependent during the grace period.

9. SECTION 8 - GENERAL PROVISIONS.

A. Section **8.2.7, Right of Recovery**, is deleted from the Certificate and replaced with the following:

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.

B. Section **8.2.10** is added to the Certificate as follows:

8.2.10 The benefits paid by the PPO 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.

C. Section **8.3, Subrogation,** is deleted from the Certificate and replaced with the following:

8.3 Subrogation and Reimbursement Rights.

8.3.1 In General. The PPO 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 PPO under this Certificate. The Member shall do nothing to prejudice the subrogation or reimbursement rights of the PPO.

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 PPO 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 PPO 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 PPO is subrogated to the Member's right to recover from the Responsible Third Party. This means that the PPO "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 PPO 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 PPO to cover the Member's injuries. Under this subrogation provision, the PPO 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 PPO 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 PPO 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 PPO 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 PPO 100% of the cost of any benefits the Member received from the PPO.

8.3.4 General Rules Governing Subrogation and Reimbursement. The PPO's subrogation and reimbursement rights shall apply regardless of whether the funds sought by the PPO 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 PPO'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 PPO'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 PPO 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 PPO agrees to do so in writing. The PPO'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 PPO's subrogation and reimbursement rights are enforceable against the heirs, estate, legal guardians or legal representatives of the Member. The PPO has the right to pursue recovery of the full reimbursement amount of the medical benefits paid by the PPO without regard to any claim of fault on the part of the Member.

The PPO 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 PPO 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 PPO 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 PPO's subrogation and reimbursement rights and may not be used in any way to reduce the PPO'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 PPO's subrogation and reimbursement rights or shall in any way reduce the PPO'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 PPO 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 PPO 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 PPO provided medical care or any benefits in any way, unless and until the PPO provides its written authorization to accept the offer. A Member must fully cooperate with the PPO, 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 PPO to fully exercise its reimbursement and subrogation rights. This includes providing the PPO with any relevant information it requests, signing and delivering such documents as the PPO 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 PPO's ability to enforce its subrogation and

reimbursement rights to the fullest extent possible. A Member must fully reimburse the PPO 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.

D. Section **8.6.1, Failure to Pay,** is deleted from the Certificate in its entirety and replaced with the following:

8.6.1 **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 PPO 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 PPO, 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.

E. Sections **8.6.2.1, Fraud or Material Misrepresentation by the Group and 8.6.2.2**, **By the Member,** are deleted from the Certificate and replaced with the following:

8.6.2.1 **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 PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

8.6.2.2 **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 PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

F. Section **8.6.7, Disruptive Behavior,** is deleted from the Certificate in its entirety.

G. Section **8.6.8, Conversion Privileges**, is deleted from the Certificate and replaced as follows:

8.6.8 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 and Mini-COBRA eligible Groups) are eligible for conversion coverage when their COBRA or Mini-COBRA eligibility for Group coverage expires.

The PPO 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 PPO 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.

H. Section **8.7.2,** regarding **Reinstatement**, is deleted from the Certificate and replaced with the following:

8.7.2 At the PPO's sole discretion, the PPO 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 PPO within sixty (60) days of the date of the initial request to terminate that termination is no longer desired.

I. Sections **8.14.1, Claims and Reimbursement,** and **8.14.2, Reimbursement,** are deleted and replaced with the following:

8.14 Claims and Reimbursement.

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

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

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

To file a claim, the Member should call the PPO 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 PPO 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-Preferred Provider and submit it, together with an itemized bill, to the following address:

Geisinger Quality Options, Inc.
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 PPO, 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 Quality Options, Inc.
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.

8.14.2 **Reimbursement.** In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, the PPO will reimburse the Member by check immediately upon receipt of written proof of claim set forth under Section 8.14.1 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 PPO as soon as possible, but in no event later than one (1) year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

J. Section **8.24, Time Limit on Certain Defenses,** is deleted and replaced with the following:

8.24 **Time Limit on Certain Defenses.**

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

8.24.2 **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 PPO, render the Certificate void from inception, provided such intentional misrepresentation of a material fact is discovered by the PPO within three (3) years of the date of issue of the Certificate.

K. **Section 8.27, Certificate of Creditable Coverage,** is deleted from the Certificate.

L. Section **8.31.10, Fraud and Abuse**, is added to the Certificate as follows:

8.31.10 **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 PPO'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.

M. Section **8.32, Headings,** is added to the Certificate as follows:

8.32 **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.

N. Section **8.33**, **Non-Discrimination**, is added to the Certificate as follows:

8.33 **Non-Discrimination.** The PPO 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.

O. Section 8.34, **Assignment of Benefit to Providers**, is added to the Certificate as follows:

8.34 **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.

10. **EXHIBITS**

A. **Exhibit 1 – GEISINGER PPO WITH NO REFERRAL SERVICE AREA.** The attached Exhibit 1 shall be effective as of the effective date of this Amendment.

B. The Certificate is amended to include the two Exhibits listed below:

Exhibit 3 - Precertification List

Exhibit 4 – Preventive Services

11. OTHER

A. This Amendment shall be effective for the Benefit Period beginning on or after April 1, 2023.

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

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

Kurt J. Wrobel
President
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220

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

Exhibit 1
GEISINGER CHOICE PPO
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 3
Precertification List

The following (A) services and/or supplies or (B) agents and/or medications require Precertification as described in Section 2. **Please note those items with an asterisk (*) are not covered when provided by Non-Preferred Providers.**

A. Services and/or Supplies Requiring Precertification:

1. Ambulance Transport Service (Non-Emergent)
2. Blepharoplasty (plastic surgery of the eyelids)
3. Breast Reduction/Reconstruction – unrelated to previous mastectomy for Breast Cancer
4. Bronchial Thermoplasty
5. Cardiac Devices: pacemaker, wearable and implantable defibrillator, ventricular assist device, left atrial appendage closure device, mobile cardiovascular telemetry, implantable loop recorder
6. Cardiac Nuclear Medicine
7. Cardiac Procedures: ablation, arrhythmia induction and mapping, angioplasty, stent, catherization, transcatheter aortic valve replacement, transcatheter mitral valve repair, patent foramen ovale and atrial septal defect closure
8. Comparative Genomic Hybridization (CGH) or Chromosomal Microarray Analysis (CMA) for Evaluation of Developmental Delay*
9. Deep Brain Stimulation
10. Durable Medical Equipment (DME)*
11. Dorsal Column Stimulation (spinal column stimulation)
12. Electrical and Electromagnetic Stimulation to promote wound healing
13. Extraction of Teeth and Alveoloplasty (limited to extractions performed by an oral surgeon that are required prior to organ transplantation, cardiac or radiation procedures)
14. Fetal Surgery (surgery on the unborn child)
15. Gastric Electrical Stimulation
16. Gender Dysphoria and Gender Confirmation Treatment
17. Genetic Susceptibility Cancer Panels
18. Genetic Testing for Mitochondrial Disorders
19. Genetic Testing Related to Colorectal Cancer*
20. Health Care Services Associated with Non-Covered Services (such as anesthesia related services to non-covered dental extractions)
21. Home Health Services
22. Inpatient Facility Admission
23. Intercostal Nerve Block
24. Interventional Pain Management
25. Intrathecal Infusion Pump
26. Lung Volume Reduction Surgery
27. Magnetic Esophageal Sphincter Augmentation
28. Mental Health and Substance Abuse Services:
    - i. Inpatient Services.
    - ii. Non-Hospital Residential Treatment Services
    - iii Precertification is required for the following non-routine outpatient services:
    - Partial Hospitalization Services
    - Intensive outpatient program treatment

- Outpatient electro-convulsive treatment
- Psychological testing and Neuropsychological testing
- Applied Behavioral Analysis (ABA)

  (No Precertification for ABA is required when a licensed clinician has diagnosed the Member receiving ABA services with an autism spectrum disorder.)
- Transcranial Magnetic Stimulation (TMS)

29. Molecular Profiling of Malignant Tumors to Identify Targeted Therapies
30. Musculoskeletal Procedures of the shoulder, hip, knee and spine
31. Non Emergency Outpatient Radiology (CT, Echocardiography, MRI, MRA, PET, Nuclear Cardiology, SPECT)
32. Non-Wearable Automatic External Defibrillator
33. Nutritional Supplements*
34. Obesity Surgery*
35. Oncotype Dx - Multi-gene Expression Assay for Predicting Recurrence in Colon Cancer *
36. Orthognathic Surgery (including, but not limited to mandibular and maxillary osteotomies)
37. Outpatient Rehabilitation Services (occupational, physical or speech therapy) - For non-back/neck related pain therapy, Precertification is only required when services are provided by Non-Preferred Providers. **NOTE:** Back/neck related pain therapy requires Precertification when services are provided by either a Preferred or Non-Preferred Provider.
38. Proton Beam Radiation
39. Restorative or Reconstructive Surgical Procedures (except for a Medically Necessary mastectomy as set forth in the Certificate which is not subject to Precertification)
40. Rhinoplasty as stand-alone procedure or Rhinoplasty with or without major septal repair in conjunction with other planned Medically Necessary surgeries
41. Septoplasty as stand-alone procedure/Septoplasty in conjunction with other planned Medically Necessary surgery
42. Skilled Nursing Facility Admission
43. Speech Generating Devices*
44. Suprascapular Nerve Block
45. Sympathetic Nerve Block
46. Termination of Pregnancy (Abortion)
47. Transoral Incisionless Fundoplication
48. Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells. *
49. Tumor Treatment Fields (Optune)
50. Vagal Nerve Stimulation (electrical stimulation for seizure control)
51. Varicose Vein Procedures (including injection of sclerosing solution into varicose leg veins and vein stripping)
52. Vertical Expandable Titanium Rib
53. Whole Exome Sequencing

B. Agents and/or Medications Requiring Precertification:

1. Abecma™ (idecabtagene vicleucel)
2. Abilify Maintena ™ (aripiprazole)
3. Abraxane ™ (paclitaxel protein-bound particles)
4. Actemra IV ™ (tocilizumab)
5. Adakveo ™ (crizanlizumab-tmca)
6. Adcetris ™ (brentuximab vedotin)

7. Akynzeo ™ IV (fosnetupitant/palonosetron)
8. Aldurazyme ™ (laronidase)
9. Aliqopa ™ (copanlisib)
10. Aloxi ™ (palonosetron)
11. Alpha 1-Antitrypsin Inhibitor Therapy
12. Ameluz ™ (aminolevulinic acid)
13. Amondys 45™ (casimersen)
14. Andexxa ™ (andexanet alfa)
15. Aralast ™ (human alpha$_1$-proteinase inhibitor)
16. Aranesp ™ (darbepoetin alfa)
17. Aristada ™ (aripiprazole lauroxil)
18. Aristada Initio™ (aripiprazole lauroxil)
19. Arranon ™ (nelarabine)
20. Arzerra ™ (ofatumumab)
21. Asceniv ™ (immune globulin)
22. Aveed ™ (testosterone)
23. Avsola ™ (infliximab-axxq)
24. Avycaz ™ (ceftazidime/avibactam)
25. Azedra ™ (iodine i-131 iobenguane, diagnostic, 1 millicurie)
26. Bavencio ™ (avelumab)
27. Baxdela ™ IV (delafloxacin)
28. Beleodaq ™ (belinostat)
29. Benlysta ™ (belimumab)
30. Beovu™ (brolucizumab)
31. Berinert ™ (C1 esterase inhibitor)
32. Besponsa ™ (injection, inotuzumab ozogamicin)
33. Bivigam ™ (intravenous immune globulin)
34. Blenrep ™ (belantamab mafodotin-blmf)
35. Blincyto ™ (blinatumomab)
36. Boniva™ IV (ibandronate sodium)
37. Botox ™ (botulinum toxin A and B)
38. Botulinum Toxin and Derivatives
39. Breyanzi™ (lisocabtagene maraleucel)
40. Brineura ™ (injection, cerliponase alfa)
41. Carimune ™ NF (intravenous immune globulin)
42. Cerezyme ™ (imiglucerase)
43. Cimzia ™ (certolizumab pegol)
44. Cinqair ™ (reslizumab)
45. Cinryze ™ (C1 esterase inhibitor)
46. Cinvanti ™ (aprepitant)
47. Clolar ™ (clofarabine)
48. Cosela™ (trilaciclib)
49. Cresemba ™ IV (isavuconazonium sulfate)
50. Crysvita™ (burosumab-twza)
51. Cutaquig™ (immune globulin subcutaneous)
52. Cuvitru ™ (subcutaneous immune globulin)
53. Cyramza ™ (ramucirumab)
54. Dacogen ™ (decitabine)

55. Dalvance ™ (dalbavancin)
56. Danyelza™ (naxitamab-gqgk)
57. Darzalex ™ (daratumumab)
58. Darzalex Faspro™ (daratumumab/hyaluronidase)
59. Durysta™ (bimatoprost intraocular implant)
60. Dysport ™ (Botulinum toxin Type A)
61. Elaprase ™ (idursulfase)
62. Elelyso ™ (taliglucerase alfa)
63. Elitek ™ (rasburicase)
64. Elzonris™ (tagraxofusp-erzs)
65. Emend ™ IV (fosaprepitant)
66. Empaveli™ (pegcetacoplan)
67. Empliciti ™ (elotuzumab)
68. Enhertu ™ (fam-trastuzumab deruxtecan-nxki)
69. Entyvio ™ (vedolizumab)
70. Epogen ™ (epoetin alfa)
71. Eraxis ™ (anidulafungin)
72. Erwinase ™ (asparaginase)
73. Erythropoietin and Darbepoetin Therapy
74. Evenity™ (romosozumab-aqqg)
75. Evkeeza™ (evinacumab-dgnb)
76. Exondys 51™ (eteplirsen)
77. Eylea ™ (aflibercept)
78. Fabrazyme ™ (agalsidase beta)
79. Fasenra ™ Prefilled Syringes (benralizumab)
80. Fensolvi™ (leuprolide)
81. Fetroja ™ (cefiderocol)
82. Flebogamma™/Flebogamma ™ DIF(intravenous immune globulin)
83. Flolan ™ (epoprostenol)
84. Fulphila™ (pegfilgrastim-jmdb)
85. Gamifant™ (emapalumab-lzsg)
86. Gammagard Liquid ™ (subcutaneous/intravenous immune globulin)
87. Gammagard S/D™ (intravenous immune globulin)
88. Gammaplex ™ (intravenous immune globuline)
89. Gamunex-C™/Gammaked™ (subcutaneous/intravenous immune globulin)
90. Gazyva ™ (obinutuzumab)
91. Gel-One ™ (hyaluronan or derivative)
92. GenVisc ™ 850 (hyaluronan or derivative)
93. Givlaari ™ (givosiran)
94. Glassia ™ (human alpha1-proteinase inhibitor)
95. Granix ™ (tbo-filgrastim)
96. Halaven ™ (eribulin mesylate)
97. Hemlibra ™ (injection, emicizumab-kxwh)
98. Hizentra ™ (subcutaneous immune globulin)
99. Hyalgan ™ (hyaluronate sodium)
100. Hymovis ™ (hyaluronan or derivative)
101. Hyqvia ™ (immune globulin/hyaluronidase)
102. Ilaris ™ (canakinumab)

103. Ilumya ™ (tildrakizumab-asmn)
104. Iluvien ™ (fluocinolone acetonide)
105. Imfinzi ™ (durvalumab)
106. Imlygic ™ (talimogene laherparepvec)
107. Inflectra™ (infliximab-dyyb)
108. Injectable Antipsychotic Medications
109. Intravenous and Subcutaneous Immune Globulin (IVIG)
110. Invega Hafyera™ (paliperidone palmitate)
111. Invega Sustenna ™ (paliperidone palmitate extended release)
112. Invega Trinza ™ (paliperidone palmitate extended release)
113. Istodax ™ (romidepsin)
114. Ixempra ™ (ixabepilone)
115. Jemperli™ (dostarlimab-gxly)
116. Jevtana ™ (cabazitaxel)
117. Kadcyla ™ (ado-trastuzumab emtansine)
118. Kalbitor ™ (ecallantide)
119. Kanuma ™ (sebelipase alfa)
120. Keytruda ™ (pembrolizumab)
121. Khapzory™ (levoleucovorin)
122. Kimmtrak™ (tebentafusp-tebn)
123. Kimyrsa™ (oritavancin)
124. Kymriah ™ (tisagenlecleucel)
125. Kyprolis ™ (carfilzomib)
126. Lemtrada ™ (alemtuzumab)
127. Leukine ™ (sargramostim)
128. Libtayo ™ (cemiplimab-rwlc)
129. Lucentis ™ (ranibizumab)
130. Lumizyme ™ (alglucosidase alfa)
131. Lumoxiti ™ (moxetumomab pasudotox-tdfk)
132. Lutathera ™ (lutetium Lu 177 dotatate)
133. Luxturna ™(voretigene-neparvovec-rzyl)
134. Makena ™ (hydroxyprogesterone caproate injection)
135. Margenza™ (vincristine sulfate liposome)
136. Marqibo ™ (vincristine sulfate liposome injection)
137. Mepsevii ™ (vestronidase alfa-vjbk)
138. Mircera ™ (epotin beta)
139. Monjuvi ™ (tafasitamab-cxix)
140. Monovisc ™ (hyaluronan or derivative)
141. Mylotarg ™ (gemtuzumab ozogamicin)
142. Myobloc ™ (Botulinum toxin Type B)
143. Naglazyme ™ (galsulfase)
144. Neulasta ™ (pegfilgrastim)/Neulasta OnPro™
145. Neupogen ™ (filgrastim)
146. Nexviazyme™ (avalglucosidase alfa-ngpt)
147. Nivestym ™ (filgrastim-aafi)
148. Nplate ™ (romiplostim)
149. Nucala ™ (mepolizumab)
150. Nulibry™ (fosdenopterin)

151. Nulojix ™ (belatacept)
152. Nuzyra ™ (omadacycline)
153. Nyvepria ™ (pegfilgrastim-apgf)
154. Ocrevus ™ (ocrelizumab)
155. Octagam ™ (intravenous immune globulin)
156. Off Label Drug Use for Oncologic Indications
157. Olinvyk™ (oliceridine)
158. Onivyde ™ (irinotecan liposome)
159. Onpattro ™ (patisiran).
160. Opdivo ™ (nivolumab)
161. Orencia ™ (abatacept)
162. Orthovisc ™ (hyaluronate sodium)
163. Oxlumo™ (lumasiran)
164. Outpatient Drug Administration at Hospital Based Infusion Center
165. Padcev ™ (enfortumab vedotinejfv)
166. Panzyga™ (intravenous immune globulin)
167. Parsabiv ™ (etelcalcetide)
168. Pepaxto™ (melphalan flufenamide hydrochloride)
169. Perseris™ (risperidone)
170. Polivy™ (polatuzumab vedotin-piiq)
171. Portrazza ™ (necitumumab)
172. Poteligeo ™ (mogamulizumab-kpkc)
173. Praxbind ™ (idarucizumab)
174. Prevymis IV™ (letermovir)
175. Prialt ™ (ziconotide intrathecal infusion)
176. Privigen ™ (intraveneous immune globulin)
177. Procrit ™ (epoetin alfa)
178. Prolastin-C ™ (human alpha$_1$-proteinase inhibitor)
179. Prolia ™ (denosumab)
180. Provenge™ (sipuleucel-T)
181. Radicava ™ (edaravone)
182. Reblozyl ™ (luspatercept-aamt)
183. Recarbrio ™ (imipenem, cilastatin and relabactam)
184. Remicade ™ (infliximab)
185. Remodulin ™ (treprostinil)
186. Renflexis ™ (infliximab-abda)
187. Retacrit ™ (epoetin alfa-epbx)
188. Revcovi ™ (elapegademase-lvlr)
189. Riabni™ (rituximab-arrx)
190. Risperdal Consta ™ (risperidone microspheres)
191. Rituxan ™ (rituximab)
192. Rituxan Hycela ™ (rituximab/hyaluronidase)
193. Ruconest ™ (C1 esterase inhibitor [recombinant])
194. Ruxience ™ (rituximab-pvvr)
195. Rybrevant™ (amivantamab-vmjw)
196. Rylaze™ (asparaginase erwinia chrysanthemi-rywn)
197. Sandostatin LAR ™ (octreotide acetate)
198. Saphnelo™ (anifrolumab-fnia)

199. Sarclisa ™ (isatuximab-irfc)
200. Scenesse ™ (afamelanotide)
201. Sevenfact ™ (antihemophilic factor, recombinant)
202. Signifor ™ LAR (pasireotide)
203. Simponi Aria ™ (golimumab)
204. Sivextro ™ (tedizolid phosphate)
205. Soliris ™ (eculizumab)
206. Spinraza ™ (nusinersen)
207. Spravato™ (esketamine)
208. Stelara ™ (ustekinumab)
209. Supprelin ™ LA (histrelin acetate implant)
210. Sustol ™ (granisetron ER)
211. Susvimo™ (ranibizumab)
212. Sylvant ™ (siltuximab)
213. Synagis ™ (palivizumab)
214. Synribo ™ (omacetaxine mepesuccinate)
215. Tecartus ™ (brexucabtagene autoleucel)
216. Tecentriq ™ (atezolizumab)
217. Tepadina ™ (thiotepa)
218. Tepezza (teprotumumab-trbw)
219. Tivdak™ (tisotumab vedotin-tftv)
220. Torisel ™ (temsirolimus)
221. Triptodur™ (triptorelin)
222. Trisenox ™ (arsenic trioxide)
223. TriVisc™ (hyaluronan or derivative)
224. Trodelvy (sacituzumab govitecan-hziy)
225. Truxima ™ (rituximab-abbs)
226. Tysabri ™ (natalizumab)
227. Udenyca™ (pegfilgrastim-cbqv)
228. Ultomiris™ (ravulizumab-cwvz)
229. Unituxin ™ (dinutuximab)
230. Uplinza ™ (inebilizumab-cdon)
231. Vabomere ™ (meropenem/vaborbactam)
232. Vabysmo™ (faricimab)
233. Varubi ™ IV (rolapitant)
234. Vectibix ™ (panitumumab)
235. Velcade ™ (bortezomib)
236. Veletri ™ (epoprostenol)
237. Viltepso ™ (viltolarsen)
238. Vimizim ™ (elosulfase alfa)
239. Visco-3 ™ (sodium hyaluronate)
240. Viscosupplementation
241. Vivaglobin (immune globulin)
242. Voraxaze ™ (glucarpidase)
243. VPRIV ™ (velaglucerase alfa)
244. Vyepti ™ (eptinezumab-jjmr)
245. Vyondys 53 ™ (golodirsen)
246. Vyxeos ™ (daunorubicin/cytarabine liposomal)

247. White Blood Cell Stimulating Factors
248. Xembify™ (intravenous immune globulin)
249. Xeomin ™ (Botulinum toxin Type A)
250. Xenleta IV™ (lefamulin)
251. Xerava ™ (eravacycline)
252. Xgeva ™ (denosumab)
253. Xiaflex™ (collaginase clostridium histolyticum)
254. Xofigo ™ (radium RA 223 dichloride)
255. Xolair ™ (omalizumab)
256. Yervoy ™ (Ipilimumab)
257. Yescarta ™ (axicabtagene ciloleucel)
258. Yondelis ™ (trabectedin)
259. Zaltrap ™ (ziv-aflibercept)
260. Zarxio ™ (filgrastim-sndz)
261. Zemaira ™ (human alpha$_1$-proteinase inhibitor)
262. Zemdri ™ (plazomicin)
263. Zepzelca ™ (lurbinectedin)
264. Zerbaxa ™ (ceftolozane/tazobactam)
265. Zevalin ™ (ibritumobab tiuxetan)
266. Ziextenzo ™ (pegfilgrastime-bmez)
267. Zilretta ™ (triamcinolone acetonide ER injection)
268. Zinplava ™ (bezlotoxumab
269. Zolgensma ™ (onasemnogene abeparvovec-xioi)
270. Zulresso ™ (brexanolone)
271. Zynlonta™ (loncastuxumab tesirine-lpyl)
272. Zyprexa Relprevv ™ (olanzapine)

Please note that those items with an asterisk (*) are not covered when performed by a Non-Preferred Provider.

Exhibit 4
Preventive 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