

Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, Pennsylvania 17822



PPO with No Referral

Subscription Certificate

This Direct Access Preferred Provider Organization Contract, called Geisinger Choice PPO with no Referral, provides hospital, medical-surgical and extended benefits utilizing Preferred Provider networks to maximize benefits. Covered Services provided by Non-Preferred Providers will generally subject the Member to an additional Coinsurance liability, except for outpatient Emergency Care or when Covered Services are not available from a Preferred Provider. In such instances, coverage increases to the Preferred Provider level of coverage. In the event that the Member requires emergency care, the PPO will provide coverage at the Preferred Provider level to a Non-Preferred Provider and the Member's out-of-pocket expense will be no greater than the amount that would have been incurred if the Member had been able to choose a Preferred Provider.

This Contract utilizes Precertification procedures, which must be followed in order to maximize coverage and avoid penalties.

GEISINGER QUALITY OPTIONS, INC.
100 North Academy Avenue
Danville, PA 17822-3220

GEISINGER CHOICE PPO WITH NO REFERRAL
Group Subscription Certificate

Thank you for choosing Geisinger Quality Options, Inc. Preferred Provider Organization (“PPO”).

Geisinger Quality Options, Inc. is a corporation located in Danville, Pennsylvania that offers the Geisinger Choice PPO with no Referral contract. **This contract provides hospital, medical-surgical and other benefits utilizing Preferred Provider services to maximize benefits. Generally, Covered Services provided by a Non-Preferred Provider will subject the Member to significant out-of-pocket expenses due to higher Cost Sharing and because such expenses are based on the PPO’s Non-Preferred Provider Fee Schedule Amounts, except for outpatient Emergency Services or when Covered Services are not available from a Preferred Provider. This Geisinger Choice PPO contract also requires Precertification procedures, which must be followed in order to maximize coverage and avoid penalties.**

To review, the coverage provided to you is defined by the following documents:

1. The Group Subscription Certificate (the Certificate), which identifies Covered Services and the terms and conditions of coverage awarded to all Members eligible for Group coverage;
2. Amendments to the Certificate, which inform Members of any changes to Covered Services or changes to the terms and conditions of coverage;
3. Riders to the Certificate, if any, which identify Supplemental Health Services covered in addition to the services included in the Certificate;
4. The Schedule of Benefits to the Certificate, which sets forth, among other things, the Member’s responsibilities for Cost Sharing such as Copayment, Deductible and Coinsurance amounts for Covered Services, including the Coinsurance Maximum liability of a Member within a Benefit Period (as applicable);
5. Enrollment Application, which is the Subscriber’s written request for enrollment;
6. The Group Master Policy, which is an agreement between the PPO and a Group for coverage arranged by the PPO to individuals eligible to receive health benefits through their employer; and
7. The Member’s Enrollment Letter.

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

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

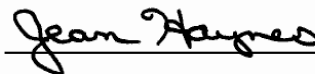
- a list of the names, business addresses and official positions of the membership of the Geisinger Quality Options, Inc. Board of Directors;
- the procedures adopted to protect the confidentiality of medical records and other Member information;
- a description of the credentialing process for Preferred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

For help and information: Members should call the Customer Service Team at the telephone number located on the back of the Member's Identification Card weekdays between 8 a.m. and 6 p.m. to obtain approval or authorization of a health care service or other information regarding the PPO. Members may also write to us at Geisinger Quality Options, Inc. PPO Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3226.

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

IN WITNESS WHEREOF,

Geisinger Quality Options, Inc.
has duly executed this Certificate



Jean Haynes
President, Chief Executive Officer
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220



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

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SECTION 1. DEFINITIONS

1. **GENERAL DEFINITIONS.** The following terms, when used in this Certificate and all applicable Amendments, Riders, and Schedule of Benefits, will have the meanings assigned to them below unless these terms are otherwise defined in such other applicable documents (please note that these terms will be capitalized when used in document text):
- 1.1 **Advance Health Care Directive** means a writing made in accordance with legal requirements that expresses a person's wishes and instructions for health care and health care directions when the person is determined to be incompetent and has an end-stage medical condition or is permanently unconscious. An Advance Health Care Directive could also be a writing made by a person designating an individual to make health care decisions for them should they be incapacitated or incompetent.
- 1.2 **Ambulatory Surgical Center** means a facility or portion thereof not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment. This does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.
- 1.3 **Amendment** is any document that describes changes to Covered Services or changes to the terms and conditions of coverage, which have become necessary between printings of the Certificate which is executed by an officer of the PPO and is to be attached to and made a part of the Certificate.
- 1.4 **Benefit Limit** means a specific limitation on a benefit which is set forth in the Schedule of Benefits, Rider(s) and/or in the Certificate as an age requirement, dollar amount or number of services covered per Benefit Period.
- 1.5 **Benefit Period** means the period of time this Certificate is in effect as indicated on the Schedule of Benefits.
- 1.6 **Certificate** refers to this document, which is provided by the PPO to all Subscribers awarded Group coverage. The Certificate describes the Covered Services and the terms and conditions of coverage.
- 1.7 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time, that provides continuation coverage to Members who incur certain qualifying events (as defined under COBRA).
- 1.8 **Coinsurance** is a form of Cost Sharing (indicated as a percentage amount on the Schedule of Benefits) which requires the Member to pay a specified portion of the Preferred Provider Fee Schedule Amount or the Non-Preferred Provider Fee Schedule Amount after the Deductible has been paid by the Member or Family Unit.
- 1.9 **Coinsurance Maximum** means the maximum dollar amount in the form of Coinsurance 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 Coinsurance Maximum does not include the following:
- (i) Deductibles;
 - (ii) Copayments;
 - (iii) amounts above a specific Benefit Limit as set forth in the Certificate and/or Schedule of Benefits;
 - (iv) amounts above the Lifetime Benefit Maximum as set forth on the Schedule of Benefits;

- (v) amounts above the PPO's Non-Preferred Provider Fee Schedule Amount; and
- (vi) amounts for non-Covered Services.

This means that the Member, not the PPO, will be responsible for payment of all these amounts noted above, even if the Coinsurance Maximum has been reached. **As item (v) can result in substantial financial responsibility for the Member, please refer to Exhibit 2 for an illustration of potential Cost Sharing when Non-Preferred Providers are utilized.**

Amounts paid toward satisfaction of the Coinsurance Maximum amounts for Covered Services obtained from either Preferred or Non-Preferred Providers accrue toward satisfaction of both Coinsurance Maximum amounts as set forth on the Schedule of Benefits. The Coinsurance Maximum applies to each Member or Family Unit subject to any family Coinsurance Maximum set forth on the Schedule of Benefits.

- 1.10 Commissioner** means the Insurance Commissioner of the Commonwealth of Pennsylvania.
- 1.11 Copayment** is a form of Cost Sharing which requires the Member to pay a fixed amount of money for the cost of Covered Services. Copayment amounts are set forth on the Schedule of Benefits and are due at the time and place such services are received by a Member. Copayment amounts do not accrue toward satisfaction of any Coinsurance Maximum or Deductible amounts.
- 1.12 Cost Sharing** means the Deductible, Copayment, Coinsurance and any amounts exceeding the Coinsurance Maximums, Benefit Limits or Lifetime Benefit Maximum amounts that a Member will incur as an expense for Covered Services. Specific Cost Sharing amounts for Covered Services can be found on the Schedule of Benefits and as to Benefit Limits, also in the Certificate and any Riders supplementing the Certificate.
- 1.13 Covered Service** means:
 - a) a Medically Necessary (unless otherwise indicated) service or supply specified in this Certificate for which benefits will be provided pursuant to the terms of the Certificate or
 - b) any Medically Necessary Supplemental Health Services set forth in any Riders supplementing this Certificate.
- 1.14 Creditable Coverage** means the length of time an enrollee had previous continuous health coverage which was not interrupted by a sixty-three (63) day break in coverage. This coverage may be credited against, and reduce the length of, any Pre-Existing Condition exclusion that may be applied by the PPO in accordance with HIPAA.
- 1.15 Custodial, Domiciliary or Convalescent Care** means services to assist an individual in the activities of daily living that do not require the continuing attention of skilled, trained medical or paramedical personnel.
- 1.16 Customer Service Team** refers to the PPO representatives who are available to answer Member's questions and provide information regarding the PPO and coverage. The telephone number for the Customer Service Team is set forth on the back of the Member's Identification Card.
- 1.17 Deductible** means a specified dollar amount for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the PPO will assume any liability for all or part of the cost of Covered Services. The Deductible applies to each Member subject to

any Family Deductible set forth on the Schedule of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers, as set forth on the Schedule of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Preferred Providers or Preferred Providers accrue toward satisfaction of both Deductible amounts as set forth on the Schedule of Benefits. In addition, certain Supplemental Health Services may have a separate Deductible, as set forth on the Schedule of Benefits and the terms of the applicable Rider. Deductible amounts must be met every Benefit Period before the corresponding Coinsurance amount applies. Copayment amounts do not accrue toward satisfaction of any Deductible amounts.

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

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

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

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

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

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

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

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

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

- a) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use (however, approval by the FDA or other federal regulatory agency does not imply that the technology is automatically considered by the PPO to be Medically Necessary or as being the accepted standard of care); or not identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Provider as being investigational, experimental, research based or educational; or
- b) The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulation. Procedures and services provided as being related to an investigational technology, or rendered as part of a clinical trial or research protocol, including, but not limited to, services and procedures that would otherwise be covered, and hospital admissions solely for the purpose of providing an investigational technology, research protocol or clinical trials are NOT COVERED, regardless of whether the trial is subject to FDA oversight; or
- c) The subject of a written research or investigational treatment protocol being used by the treating Provider or by another Provider who is studying the same service.
- d) If the requested service is not represented by criteria a, b, or c as listed above, the PPO reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:
 - (i) the service has a measurable, reproducible positive effect on the health outcomes as evidenced by well designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use; and
 - (ii) the proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied; and
 - (iii) the improvement in health outcome is attainable outside of the clinical investigation setting; and
 - (iv) the majority of Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and
 - (v) the beneficial effect on health outcomes outweighs any potential risk or harmful effects.

1.25 Family Coverage means the Covered Services provided under this Certificate for a Subscriber and one or more Family Dependents who are Members under the same Certificate.

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

- a) who meets all the requirements as set forth in Section 6.2 of this Certificate and any additional requirements set forth in the Group Master Policy;
- b) who is enrolled under this Certificate;
- c) for whom the applicable premium for Family Coverage has been paid; and
- d) a Family Dependent is also a Member as defined in Section 1.42 of this Certificate.

- 1.27 Family Unit** means the Subscriber and his or her Family Dependents.
- 1.28 Group** means the employer, association, union or trust through which the Subscriber is enrolled and who agrees to remit premiums for coverage payable to the PPO. The Group is identified on the Schedule of Benefits.
- 1.29 Group Master Policy** means the agreement between the PPO and the Group providing for the administration of enrollment, payment of premiums, and other matters pertaining to the provision of health care benefits under the terms of this Certificate for persons who meet the requirements of the Group to participate in the Group's health benefit's plan.
- 1.30 Health Care Provider or Provider** means a licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under any applicable law, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.
- 1.31 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) limiting exclusions for Pre-Existing Conditions (as defined under HIPAA);
 - b) prohibiting discrimination against employees and dependents based on their health status;
 - c) guaranteeing renewability and availability of health coverage to certain employers and individuals;
 - d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and
 - e) regulating the use and disclosure of protected health information.
- 1.32 Hospice.** The following definitions **only apply** to Hospice services.
- 1.32.1 Continuous Care** means a level of continuous and uninterrupted care which is:
- a) necessary due to periods of crisis resulting from a Member's deteriorating medical condition and/or the Member's family's inability to provide the level of care necessary to maintain the Member at home; and
 - b) provided in the Member's home by qualified professionals for a period of at least eight (8) hours until such care is deemed no longer Medically Necessary by the PPO.
- 1.32.2 General Inpatient Care** means a level of care involving Hospice-supervised inpatient services in accordance with the Member's Plan of Care including, without limitation, services necessary for pain control or symptom management during one (1) or more days, including overnight stays, in an inpatient setting to include either a hospital, skilled nursing facility, or hospice inpatient facility.
- 1.32.3 Hospice** means a Covered Service rendered by a Preferred Provider who is licensed as a provider of Hospice services in the Commonwealth of Pennsylvania and is a certified provider of Hospice services under Medicare.
- 1.32.4 Hospice Medical Director** means a physician who is licensed in the Commonwealth of Pennsylvania to practice medicine and is employed by Hospice either directly or

under contractual arrangement to provide physician services to the Hospice patient in accordance with such patient's Plan of Care.

- 1.32.5 **Interdisciplinary Group** means a group of Hospice employees including, but not limited to, a doctor of medicine or osteopathy, registered nurse, and a pastoral or other counselor, who are responsible for:
- a) establishing the Plan of Care;
 - b) periodically reviewing and updating the Plan of Care;
 - c) providing or supervising the provision of services offered by the Hospice; and
 - d) developing policies regarding the day-to-day provision of care by the Hospice.
- 1.32.6 **Plan of Care** means a written individualized care plan which:
- a) is established, maintained and reviewed at periodic intervals for the Member by the Hospice Medical Director or physician designee, the Member's physician Preferred Provider and the Interdisciplinary Group;
 - b) includes an assessment of the Member's needs and assignment of a level of Hospice care; and
 - c) details the scope and frequency of services to be provided for the Member's Terminal Illness.
- 1.32.7 **Respite Care** means a level of care involving Hospice-supervised inpatient services, in accordance with the Member's Plan of Care, to provide the Member's family with a reprieve from caring for the Member at home when the Member does not have any symptoms which would otherwise require inpatient services. Respite Care shall:
- a) include care for one (1) or more days, including overnight stays, in an inpatient setting to include either a hospital, skilled nursing facility or a Hospice inpatient facility; and
 - b) not exceed five (5) days per admission.
- 1.32.8 **Routine Home Care** means a level of intermittent and part-time care provided in accordance with a Member's Plan of Care and rendered by qualified professionals in the Member's home. Such care shall include nursing services, social services, physical therapy, occupational therapy, speech pathology, and counseling and support services for both the Member and the Member's family.
- 1.32.9 **Terminal Illness** means an incurable illness or other condition with a medical prognosis of life expectancy of six (6) months or less.
- 1.33 Identification Card** means the card issued by the PPO to a Member pursuant to this Certificate which is for identification purposes only. Possession of an Identification Card confers no right to Covered Services or other benefits under this Certificate. To be entitled to Covered Services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable premiums and charges under this Certificate have actually been paid.
- 1.34 Legal Custody** means the legal right to make major decisions affecting the best interest of a minor including, but not limited to, medical, religious and educational decisions pursuant to 23 Pa. C.S.A. Section 5302.

- 1.35 Legal Guardian or Legal Guardianship** means the appointment of a guardian by a court of an incapacitated person pursuant to 20 Pa. C.S.A. Section 5521.
- 1.36 Level 1 Bariatric Center of Excellence** is an institution which meets certain accreditation standards and is designated by either the American Society of Bariatric Surgery or American College of Surgeons as a Level 1 Bariatric Center of Excellence.
- 1.37 Lifetime Benefit Maximum** means the maximum amount of Covered Services that the PPO will cover during a Member's lifetime under this Certificate, as set forth on the Schedule of Benefits. This could be expressed in dollars, number of days or number of services.
- 1.38 Maximum Age** means the point in time which a Family Dependent is no longer eligible for coverage as described in Section 6.2 and as set forth on the Schedule of Benefits.
- 1.39 Medical Director** means the licensed physician designated by the PPO to direct the medical and scientific aspects of the PPO, and to oversee the quality and appropriateness of the managed health services.
- 1.40 Medical Necessity or Medically Necessary** means Covered Services rendered by a Health Care Provider that the PPO determines are:
- a) appropriate for the symptoms and diagnosis and treatment of the Member's condition, illness, disease or injury;
 - b) provided for the diagnosis, and the direct care and treatment of the Member's condition, illness, disease or injury;
 - c) in accordance with current standards of good medical treatment practiced by the general medical community;
 - d) not primarily for the convenience of the Member, or the Member's Health Care Provider; and
 - e) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.
- 1.41 Medicare** means the programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.
- 1.42 Member** means an individual eligible to receive Covered Services or benefits under the terms of this Certificate either as the Subscriber or an eligible enrolled Family Dependent.
- 1.43 Network** means the Health Care Providers who have entered into a written agreement with the PPO to provide Covered Services to Members as part of the PPO's panel of Preferred Providers.
- 1.44 Non-Preferred Provider** means a Health Care Provider or Provider that does not have an agreement with the PPO to provide Covered Services to the PPO's Members and is not part of the PPO's Network.
- 1.45 Non-Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Non-Preferred Provider which is generally a percentage of Medicare reimbursement. The Member may obtain the

Non-Preferred Provider Fee Schedule Amount by contacting the Customer Service Team at the number set forth on the Identification Card.

- 1.46 Open Enrollment Period** means those periods of time established by the Group and the PPO from time to time, during which eligible persons may enroll.
- 1.47 Orthotic Device** means a rigid appliance or apparatus used to support, align or correct bone and muscle deformities.
- 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 Section 2.3 of this Certificate are reviewed by the PPO for coverage determination based on Medical Necessity prior to the provision of services.
- 1.49 Pre-Existing Condition** means a limitation or exclusion of benefits relating to a condition (mental or physical) regardless of the cause of the condition, for which medical advice, diagnoses, care, or treatment was recommended or received within one hundred eighty (180) days immediately prior to the enrollment date.
- 1.50 Preferred Facility Provider** means a hospital, facility or institution licensed, certified or otherwise regulated under the laws of the Commonwealth of Pennsylvania, or another state, as applicable, that has an agreement with the PPO to provide Covered Services to Members as a Preferred Provider.
- 1.51 Preferred Provider or Preferred Health Care Provider** means a Health Care Provider that has an agreement with the PPO pursuant to which negotiated rates are established on a Preferred Provider basis for payment of Covered Services to Members under this Certificate and pursuant to which such Health Care Provider is a part of the PPO's Network. The PPO contracts with a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Preferred Providers.
- 1.52 Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Preferred Provider based on the contractual arrangement between the PPO and the Preferred Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Member.
- 1.53 Preferred Provider Organization (PPO)** means Geisinger Quality Options, Inc.
- 1.54 Primary Care Services** means initial and basic medical health care services provided by a general or family care practitioner, internist or pediatrician.
- 1.55 Prosthetic Device** means an appliance or apparatus which replaces a missing body part.
- 1.56 Provider.** A Preferred or Non-Preferred Provider, including a physician, medical group, pharmacy, hospital, or other provider of health services, licensed, certified or otherwise regulated under any applicable law.
- 1.57 Provider List** means a published listing (as amended from time to time) provided to Members by the PPO which sets forth the names, addresses and telephone numbers of current

Preferred Providers who have contracted with the PPO to provide Covered Services. The current Provider List can be found on the PPO's website (at www.thehealthplan.com). A Member may also request a copy of the most current Provider List by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card or by writing to the Customer Service Team at the address listed on page (iii) of this Certificate.

- 1.58 Rider** means a document that describes the terms and conditions applicable to specific Supplemental Health Services purchased by the Group to be in effect for the Subscriber and all Family Dependents enrolled under this Certificate. All Riders in force under this Certificate are listed on the current Schedule of Benefits.
- 1.59 Schedule of Benefits** is a summary of coverage for a Member that identifies the Maximum Age for dependent coverage together with the applicable Deductible, Copayments, Coinsurance, Coinsurance Maximums, Benefit Limits and Lifetime Benefit Maximum amounts for Covered Services, and any Riders in force for the Certificate. If there is a change in any of the information printed on the Schedule of Benefits (for example, an item has been printed incorrectly or the wrong Schedule of Benefits has been provided), the PPO will issue a new Schedule of Benefits to replace all prior Schedules of Benefits.
- 1.60 Service Area** means the Pennsylvania counties listed in Exhibit 1, as amended from time to time, for which the PPO is licensed to operate by the Pennsylvania Department of Health.
- 1.61 Specialist** means a Provider whose practice is not limited to Primary Care Services and who has additional post graduate or specialized training, board certification or practices in a licensed specialized area of health care.
- 1.62 Subscriber** means an individual who meets the requirements for eligibility, who has enrolled in the PPO, and for whom payment has actually been received by the PPO. A Subscriber is also a Member.
- 1.63 Substance Abuse** means any use of drugs and/or alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- 1.64 Supplemental Health Services** are those benefits provided under the Riders listed on the Schedule of Benefits.
- 1.65 Tel-A-Nurse** is the twenty-four (24) hour a day access to nurse advice available to Members by the toll free number set forth on the Member Identification Card or by "live chat" on the PPO's website at www.thehealthplan.com. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.
- 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.

SECTION 2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS

2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS.

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

- a) Non-emergency inpatient admissions and certain designated services and procedures identified in this Section received from Non-Preferred Providers or Preferred Providers **REQUIRE** Precertification by the PPO as set forth in this Section.
- b) The PPO case management nursing staff is available to work with Members who require transplants, who have catastrophic disease or injury, are temporarily outside the Service Area and require Urgent Care, who can benefit from individualized attention to coordinate their needs, or who are otherwise recommended for case management.
- c) The PPO medical management staff coordinates with the quality improvement staff to collect data and review issues to assure appropriate care in the most efficient manner.
- d) 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.
- e) A PPO Medical Director will be involved in any decision to deny coverage on the basis of Medical Necessity.

The PPO's medical management policies and procedures comply with all applicable state and federal regulations regarding medical management and utilization.

2.2 Precertification. The purpose of Precertification is to encourage and facilitate use of the most appropriate level of care for Medically Necessary services utilizing industry accepted criteria for severity of illness and intensity of service. 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.

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

- a. Advanced Molecular Topographic Genotyping*
- b. Bioengineered Skin Equivalents (Dermagraft™ and Apligraf™ (Graftskin) – a type of skin graft)
- c. Blepharoplasty (plastic surgery of the eyelids)
- d. Carotid Artery Stenting
- e. Cochlear Implants (surgically implanted hearing device)
- f. Deep Brain Stimulation
- g. Dorsal Column Stimulation (spinal column stimulation)
- h. Durable Medical Equipment (DME)*
- i. Electrical Stimulation to aid bone healing; invasive procedure (surgical procedure related to bone growth stimulator)
- j. External Counterpulsation Therapy

- k. Extracorporeal Shock Wave Treatment (ESWT) for Musculoskeletal Indications
- l. Extraction of Teeth, Alveoloplasty, and Excision of Tori (limited to extractions performed by an oral surgeon that are required prior to organ transplantation, cardiac or radiation procedures)
- m. Fetal Surgery (surgery on the unborn child)
- n. Gene Expression Profiling for Breast Cancer*
- o. Health Care Services Associated with Non-Covered Services (such as anesthesia related to non-covered dental extractions)
- p. Home Health Services (including home infusion services)
- q. Injection Therapy for Back Pain*
- r. Inpatient Facility Admission
- s. Intensity Modulated Radiation Therapy (IMRT)
- t. Kyphoplasty (a type of surgery on the vertebrae of the spine)
- u. Mental Health and Substance Abuse (Inpatient and Partial Hospitalization) Services
NOTE: For Members of Groups of 51 or more (refer to the bottom of your Schedule of Benefits to determine if you are in such a Group of 51+), Precertification is required when mental health and Substance Abuse partial hospitalization services are obtained from a Provider who does not participate in the PPO's Designated Behavioral Health Benefit Program.
- v. Non-Emergency Outpatient Radiology (CT, MRI, MRA, PET, Nuclear Cardiology, Virtual Colonoscopy)
- w. Obesity Surgery*
- x. Orthognathic Surgery (jaw surgery to correct skeletal deformity)
- y. Outpatient Rehabilitation Services (occupational, physical or speech therapy)
- z. Pectus Excavatum or Carinatum (surgical correction of chest deformity)
- aa. Proton Beam Radiation
- bb. Restorative or Reconstructive Surgical Procedures (except for a Medically Necessary mastectomy as set forth in Section 3.14 of this Policy which is not subject to Precertification)
- cc. Rhinoplasty as stand alone procedure or Rhinoplasty with Major Septal Repair
- dd. Sacral Nerve Stimulation (treatment to improve bladder control)
- ee. Septoplasty as stand alone procedure/Septoplasty in conjunction with other planned Medically Necessary surgery
- ff. Skilled Nursing Facility Admission
- gg. Stereotactic Radiosurgery (including but not limited to Cyberknife, GammaKnife, LINAC, Neuromate, Nerhkoordinaten Manipulator (MKM))
- hh. Transmyocardial Laser Revascularization (TMLR) (when performed as a stand-alone procedure – process to increase blood supply to the heart)
- ii. Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells. **NOTE:** Inpatient hospitalization for transplant services may not be obtained from Non-Preferred Providers.
- jj. Unilateral Pallidotomy (treatment for Parkinson tremor)
- kk. Vagal Nerve Stimulation (electrical stimulation for seizure control)
- ll. Varicose Vein Procedures (including injection of sclerosing solution into varicose leg veins and vein stripping)
- mm. Vertebroplasty (type of surgery on the vertebrae of the spine)
- nn. The Following Agents/Medications Require Precertification by the PPO:

- Abraxane™ (paclitaxel protein-bound particles)
- Aldurazyme™ (laronidase)
- Alpha 1- Antitrypsin Inhibitor Therapy
- Amevive™ (alefacept)
- Aralast™
- Aranesp™ (darbepoetin)
- Arranon™ (nelarabine)
- Avastin™ (bevacizumab)
- Bexxar™ (tositumomab and iodine 131 tositumomab)
- Botox™ (botulinum toxin A)
- Cerezyme™ (imiglucerase)
- Clolar™ (clofarabine)
- Cubicin™ (daptomycin)
- Dacogen™ (decitabine)
- Degarelix™
- Elaprase™ (idursulfase)
- Elitek™ (rasburicase)
- Eloxatin™ (oxaliplatin)
- Epogen™ (erythropoietin)
- Eraxis™ (anidulafungin)
- Erbitux™ (cetuximab)
- Erythropoietin Stimulating Agents
- Fabrazyme™ (agalsidase beta)
- Faslodex™ (fulvestrant)
- Flolan™ (epoprostenol)
- Herceptin™ (trastuzumab)
- Hyalgan™
- Implanon™ (etonogestrel implant)
- Intravenous (IV) Boniva (ibandronate sodium)
- Intravenous Immune Globulin (IVIG)
- Ixempra™ (ixabepilone)
- Leukine™ (sargramostim)
- Mozibill™ (plerixafor)
- Myobloc (botulinum toxin Type B)
- Myozyme™ (alglucosidase alfa)
- Naglazyme™ (galsulfase)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Nplate™ (romiplostim)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Orthovisc™
- Prial™ (ziconotide intrathecal infusion)
- Procrit™ (erythropoietin)
- Prolastin™
- Reclast™ (zoledronic acid)
- Remicade™ (infliximab)

- Remodulin™ (Intavenous)
- Retisert™ (fluocinolone acetonide, intravitreal implant)
- Rituxan™ (rituximab)
- Soliris™ (eculizumab)
- Supartz™
- Supprelin™ LA (histrelin acetate implant)
- Synagis™ (palivizumab)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Tysabri™ (natalizumab)
- Vectibix™ (panitumumab)
- Velcade™ (bortezomib)
- Vfend™ (voriconazole)
- Vitrasert (ganciclovir intravitreal implant)
- Vivitrol™ (naltrexone)
- White Blood Cell Stimulating Factors
- Xolair™ (omalizumab)
- Zemaira™
- Zevalin™ (ibritumobab tiuxetan)

* The following services or supplies require Precertification. Please note those items with an asterisk (*) are not covered when provided by Non-Preferred Providers:

2.3.1 **Precertification Process.** The Precertification process begins when a non-emergency inpatient hospital admission or designated procedure or service identified in this Section is proposed.

- a) If the Member chooses to utilize a **Preferred Provider** for an inpatient hospital admission or the procedures or services indicated in this Section, ***such Preferred Provider*** is responsible for obtaining Precertification from the PPO before the inpatient hospital admission or designated procedure or service occurs. In the event the Preferred Provider fails to obtain Precertification as required, the Member will not be held financially accountable for such services.
- b) If the Member chooses to utilize a **Non-Preferred Provider**, the **Member** is responsible for (i) informing the Non-Preferred Provider that Precertification is required prior to receiving the procedure or service and (ii) ensuring that Precertification is obtained from the PPO prior to receiving the procedure or service. The Member may do this by contacting the Customer Service Team at the telephone number listed on the back of the Member's Identification Card.
- c) Both the Preferred Provider and the Non-Preferred Provider, as applicable, will need to provide the PPO with medical information. A decision regarding coverage of proposed services will be made within the time frames required by applicable law.
- d) Written notification of approval or denial of the proposed services will be provided to (i) the Member and the Preferred Provider or (ii) the Member and the Non-Preferred Provider, as applicable, within the time frames required by applicable law. **PLEASE NOTE THAT THE PRECERTIFICATION**

PROCESS HAS NOT BEEN COMPLETED IF A NOTIFICATION LETTER HAS NOT BEEN RECEIVED BY THE MEMBER.

Members dissatisfied with the results of the Precertification process may use the established appeal procedure set forth in Section 5 of this Certificate. Members and Providers will receive detailed instructions regarding the appeal process as an attachment to the notification letter, as appropriate.

- 2.3.2 **Ultimate Responsibility for Precertification When the Member Chooses to Utilize a Non-Preferred Provider.** Although a Non-Preferred Provider may contact the PPO for Precertification on the Member's behalf, **it is ultimately the responsibility of the Member to ensure that Precertification occurs prior to the date of service when the Member chooses a Non-Preferred Provider for the services and procedures set forth in this Section.**
- 2.3.3 **Failure to Precertify.** All services and procedures identified in this Section which are rendered by a Non-Preferred Provider and which **REQUIRE** Precertification are **NOT COVERED** when Precertification is not obtained.

SECTION 3. COVERED SERVICES

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

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

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

- 3.1** The following Sections set forth how a Member may obtain services from a Non-Preferred Provider without incurring Non-Preferred Provider Cost Sharing (Section 3.1.1), coverage parameters regarding Covered Services (Sections 3.1.2.), Covered Service location Cost Sharing (Section 3.1.3), and Supplemental Health Services (Section 3.1.4).

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

- 3.1.1 Covered Services from a Non-Preferred Provider.** The following are exceptions where Covered Services may be obtained from a Non-Preferred Provider without incurring Non-Preferred Provider Cost Sharing:

- a) Emergency Services as set forth in Section 3.7 of this Certificate;
- b) Urgent Care as set forth in detail in Section 3.31 of this Certificate;
- c) when the Member's medical condition requires Covered Services which cannot be provided by a Preferred Provider; or
- d) for Covered Services under this Certificate in accordance with the continuation of benefits provisions set forth in Section 8.9.

3.1.2 The PPO's Coverage of Covered Services:

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

- 3.1.2.2 **Covered Services Obtained Outside the Service Area.** Covered Services required as a result of circumstances that reasonably could have been foreseen prior to the Member's departure from the Service Area and Covered Services which can be delayed until the Member's return to the Service Area are covered at the Non-Preferred Provider rate.
- 3.1.2.3 **Maternity care outside the Service Area.** Maternity care for normal term delivery if received outside the Service Area will not be covered at the Preferred Provider rate if rendered by a Non-Preferred Provider. Treatment of unexpected complications of pregnancy and care for unexpected early delivery are covered as Emergency Services.
- 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 Copayment based on the type of facility where the Covered Service is provided. This Copayment is in addition to any Cost Sharing obligation for the Covered Service being provided to the Member.
- 3.1.4 **Supplemental Health Services as set forth in Rider(s).** The Member's Schedule of Benefits will list any Rider(s) supplementing this Certificate as well as the Member's Cost Sharing obligations related to the Rider(s). Members should note that the conditions listed above in Sections 3.1.1, 3.1.2 and 3.1.3 will also apply to the Supplemental Health Service Benefits set forth in the Rider(s). The terms and conditions of each Rider will detail how these Sections apply to the Supplemental Health Services provided by the Rider. If a Rider is listed as an exception to a Benefit in this Section 3, the Member should pay particular attention to the terms of that Rider (if in force with their Certificate) as the benefit will differ from that listed in this Section.

IDENTIFICATION OF COVERED SERVICES

Subject to all terms, conditions, definitions, exclusions and limitations in this Certificate, Members are entitled to receive the following Covered Services as set forth in this Section. All Covered Services must be Medically Necessary except for **Preventive Services** as set forth in Section 3.22 of this Certificate.

- 3.2 **Cardiac Rehabilitation.** Outpatient cardiac rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period.
- 3.3 **Diabetic Medical Equipment, Supplies, Prescription Drugs and Services.** The following diabetic medical equipment, supplies, prescription drugs and services for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are covered if prescribed by a health care professional legally authorized to prescribe such items under law when provided by a Preferred Provider. The PPO reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.
- 3.3.1 **Diabetic Medical Equipment.** The PPO will cover standard diabetic medical equipment including insulin infusion devices, blood glucose monitors, insulin pumps and injection aids. Injection aids shall include needle-free injection devices, bent needle set for insulin pump infusion and non-needle cannula for insulin infusion.
- 3.3.2 **Diabetic Foot Orthotics.** The PPO will cover diabetic foot orthotics only when provided by a Preferred Provider.

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

3.3.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered when provided at an approved PPO program site 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:

- i) upon the diagnosis of diabetes;
- ii) under circumstances whereby the Preferred Provider identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a Member's self-management; and
- iii) where a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes has been identified as appropriate by the Preferred Provider.

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

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

3.5 **Disease Management Programs.** The PPO offers programs focused on clinical health conditions including education and management. Participation in a PPO disease management/care management program may include coverage for certain services that would not otherwise be provided for under this Certificate.

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

3.6.1 **Definitions.** For the purposes of this **Durable Medical Equipment, Orthotic Devices and Prosthetic Devices** Section and Section 4.59 of **EXCLUSIONS**, the following definitions shall apply:

- a) **Compliance or Compliant** means a Member's willingness to follow a prescribed course of treatment. Coverage of Durable Medical Equipment is contingent upon a Member's Compliance in using the equipment as indicated in the course of treatment as determined by the PPO.
- b) **Deluxe Equipment** is equipment which has features that do not contribute significantly to the therapeutic function of the equipment, are only primarily beneficial in performing leisure or recreational activities or are essentially non-medical in nature.
- c) **Related Supplies** means medical supplies which are required to support the use of covered Durable Medical Equipment.

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

3.6.2 **Durable Medical Equipment (DME) and Related Supplies.** Upon Precertification by the PPO, the PPO will cover the cost of renting, or at its option, purchasing Medically Necessary Standard DME and Related Supplies when prescribed in advance by a Preferred Provider for use consistent with required Food and Drug Administration (FDA) approved labeling for the item. This benefit includes the cost of delivery and installation. Repair and replacement of DME is covered only to the extent required as a result of normal wear and tear. DME must be obtained from a Preferred Provider. The PPO reserves the right to recover any DME purchased by the PPO when such device or piece of equipment is no longer Medically Necessary or in the event that the Member is not Compliant in utilization of the equipment as indicated in the course of treatment and determined by the PPO. Coverage of DME is subject to the Exclusions set forth in Section 4.59 of this Certificate.

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

3.6.2.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Standard Durable Medical Equipment 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.

3.6.3 **Orthotic Devices.** The PPO will pay for the purchase of Standard Orthotic Devices when prescribed in advance by a Preferred Provider or when approved in advance by the PPO. Standard Orthotic Devices must be obtained from a Preferred Provider unless authorized in advance by the PPO. Coverage of Orthotic Devices is subject to the Exclusions set forth in Section 4.59 of this Certificate.

3.6.4 **Prosthetic Devices.** The PPO will pay for the purchase of Standard Prosthetic Devices, or the replacement of component parts or modification of a Standard Prosthetic Device when prescribed in advance by a Preferred Provider or when approved in advance by the PPO. Standard Prosthetic Devices must be obtained from a Preferred Provider unless authorized in advance by the PPO. This benefit applies to: (i) a new Standard Prosthetic Device; and (ii) a new Standard Prosthetic Device or replacement of an existing Standard Prosthetic Device every five (5) years. However, the initial and subsequent Prosthetic Devices following a mastectomy to replace the removed breast or portions thereof are not subject to the five (5) year Benefit Limit set forth above. Coverage of Prosthetic Devices is subject to the Exclusions set forth in Section 4.59 of this Certificate.

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

3.6.4.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Standard 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.

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

3.7 **Emergency Services.** Emergency Services do not require Precertification by the PPO. Coverage for Emergency Services provided during the period of the emergency shall include evaluation, testing, and if necessary, stabilization of the condition of the Member. The use of emergency transportation and related Emergency Services provided by a licensed ambulance service shall be covered as an Emergency Service subject to the limitations in this Section. If a Member requires Emergency Services and cannot be attended to by a Preferred Provider, the PPO shall cover the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Preferred Provider, subject to Sections 3.7.1(d) and 3.7.2 below.

3.7.1 **Emergency Services Protocol.**

- a) When an emergency happens, the Member should call 911 or an emergency information center in his area, or safely proceed immediately to the nearest Emergency Services Health Care Provider.
- b) If a Member requires hospitalization following an emergency, the Emergency Services Health Care Provider is responsible to notify the PPO within forty-eight (48) hours, or on the next business day, whichever is later, of the Emergency Services rendered to the Member.
- c) If the Member is not admitted to a hospital or other health care facility, the claim for reimbursement for Emergency Services provided shall serve as notice to the PPO of the Emergency Services provided by the Emergency Services Health Care Provider.
- d) Medically Necessary follow-up services after the initial response to an emergency are not Emergency Services.
- e) Medically Necessary follow-up services obtained from a Non-Preferred Provider after the initial response to an emergency are not Emergency Services.
- f) For the emergency treatment of sound, natural teeth please refer to Section 3.19.2, Oral Surgery. The need for these services must result from an accidental injury (not chewing or biting).

3.7.2 **Non-Preferred Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Preferred Provider, the PPO shall pay for the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Preferred Provider. However, Emergency Services provided by Non-Preferred Providers will be covered as if provided by a Preferred Provider only until the PPO determines the Member's condition has stabilized and the Member can be transported to a Preferred Provider without suffering detrimental consequences or aggravating the Member's condition. The Member may continue to use the Non-Preferred Provider at the Non-Preferred Provider rates.

- 3.7.3 **Cost Sharing.** Emergency Services are subject to the Cost Sharing amounts 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 set forth in Section 1.21 of the Certificate and this Section 3.7 are satisfied.
- 3.8 **Enteral Feeding/Food Supplements.** The cost of outpatient enteral tube feedings including administration, supplies and formula used as food supplements is covered for nutritional supplements for the therapeutic treatment of aminoacidopathic hereditary metabolic disorders (phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria) when administered under the direction of a physician Preferred Provider.
- 3.9 **Foot Care Services.** Foot care and treatment for disease, injury and related conditions of the feet are covered except as set forth in Section 4.21 and 4.58.3 of this Certificate.
- 3.10 **Home Health Care.** Upon Precertification by the PPO, home health care is covered only in the event a Member is homebound except as provided in Section 3.10.4 of this Certificate. A Member shall be considered homebound when the medical condition of the Member prohibits the Member from leaving home without extraordinary effort, unless the absences from home are attributable to the Member's need to receive medical treatment which cannot be reasonably provided in the home such as physician appointments, diagnostic or therapeutic procedures. This Section does not apply to home health care services for follow-up maternity care for early discharge which is set forth at Section 3.15 of this Certificate.

If the Member has an approved treatment plan established by a home health agency Provider and a physician Provider, then the following home health care services are covered:

- 3.10.1 **Skilled Nursing Personnel.** Skilled nursing visits in the home that are provided by skilled nursing personnel who are supervised by physician Providers, are covered upon Precertification by the PPO in accordance with Section 2 of this Certificate.
- 3.10.2 **Physician Services.** When the nature of the illness dictates, care in the home by a physician is covered. Precertification is required in accordance with Section 2 of this Certificate.
- 3.10.3 **Other Health Care Personnel.** Medical care in the home is covered when the care is given by Health Care Providers (including but not limited to, speech, physical and occupational therapists) under the supervision of a physician Provider. This care is covered upon Precertification by the PPO, subject to any specific benefit limitations set forth in this Section 3 of the Certificate.
- 3.10.4 **Follow-Up Care Post-Mastectomy Surgery.** One (1) home health visit after discharge of mastectomy surgery is covered provided that the discharge occurs within forty-eight (48) hours of admission for mastectomy surgery whether or not the Member is homebound.
- 3.11 **Hospice.** The following services for Hospice are covered: Routine Home Care, Continuous Care, General Inpatient Care, and Respite Care, as well as those Hospice services noted in this Certificate, provided such care is:
- a) prescribed in advance by a physician Preferred Provider and upon Precertification by the PPO; and

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

3.12 Hospital and Ambulatory Surgical Center Services.

3.12.1 **Benefits.** Hospital benefits may be provided at a hospital Provider on either an inpatient or outpatient basis or at an Ambulatory Surgical Center. Hospital services include semi-private room and board (private room when determined Medically Necessary by the PPO), general nursing care and the following additional facilities, services and supplies as prescribed by a physician Provider: use of operating room and related facilities; use of intensive care unit or cardiac care unit and services; radiology, laboratory, and other diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; physical therapy, occupational therapy and speech therapy (subject to the Benefit Limits set forth in Section 3.24 of this Certificate and on the Schedule of Benefits); radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma and medical social services; cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

3.12.2 **Precertification.** All non-emergency inpatient hospital admissions require Precertification as detailed in Section 2.3.1 of this Certificate.

3.12.3 **Duration of the Benefit.** Inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the PPO and not determined to be Custodial, Convalescent or Domiciliary Care, except for mastectomy Covered Services as set forth in Section 3.14 of this Certificate. In addition, the number of inpatient days when utilizing a Non-Preferred Provider is specified on the Schedule of Benefits.

3.13 **Implanted Devices.** The following implanted devices are covered: implanted devices for purposes of drug delivery; cardiac assistive devices; cochlear implants and artificial joints. These devices are only covered to correct dysfunction due solely to disease or injury and not for gender reassignment.

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

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

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

- a) reconstruction of the breast on which the mastectomy was performed; 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.

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 a 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 Policy.

3.15.1 **Cost Sharing.** The office visit Copayment or Coinsurance amount 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 for maternity are subject to the inpatient hospital Copayment or Coinsurance amount 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 an early discharge is not subject to any Copayment, Deductible or Coinsurance amounts under this Section.

3.16 Mental Health and Substance Abuse Services.

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

3.16.1 Mental Health Services (Members of Groups with fifty (50) or less employees).

All professional mental health Covered Services must be obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional who participates with the PPO's Designated Behavioral Health Benefit Program. A Member may access mental health Covered Services in the following manner:

- a) as a hospital inpatient as set forth in Section 3.21.2 (b) of this Certificate;
- b) as an outpatient for a maximum of thirty (30) outpatient visits for either individual or group therapy (or a combination of both) during each Benefit Period;
- c) pursuant to the terms and conditions of the following Riders if they are in force with the Member's Certificate:
 - 1) Mental Health Inpatient and Partial Hospitalization Services;
 - 2) Non-Serious Inpatient Mental Illness Services (Mental Health Parity - Groups of 50); and/or
 - 3) Serious Mental Illness Services (Groups of 50).

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

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

- a) **Detoxification** means the process whereby an alcohol or drug intoxicated or dependent Member is assisted in a facility or by a Provider that participates in the PPO's Designated Behavioral Health Benefit Program through the period of time necessary to eliminate by metabolic or other means 1) the intoxicating alcohol or drugs, 2) the alcohol and drug dependency factors or 3) alcohol in combination with drugs as determined by a Provider Physician, while minimizing the physiological risk to the Member.
- b) **Opioid** refers to natural and synthetic chemicals that have opium-like narcotic effects when ingested. Opioids include pain medications such as Vicodin™ and OxyContin™.

3.16.2.2 Inpatient Detoxification. Detoxification and related medical treatment for Substance Abuse, when provided on an inpatient basis in a hospital which

participates in the PPO's Designated Behavioral Health Benefit Program, or in an inpatient non-hospital facility which participates in the PPO's Designated Behavioral Health Benefit Program, is covered. The following inpatient Detoxification Services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

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

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

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

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

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

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

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

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

- b) a total Lifetime Benefit Maximum of ninety (90) days per a Member's lifetime.

3.16.4.2 Outpatient Rehabilitation Services for Substance Abuse. Outpatient rehabilitation services for Substance Abuse are covered when provided by a facility which participates in the PPO's Designated Behavioral Health Benefit Program. The following Outpatient facility rehabilitation services for Substance Abuse are covered when administered by an employee of the facility: physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies. Outpatient rehabilitation services for Substance Abuse shall be limited to:

- a) a Benefit Limit of thirty (30) outpatient, full-session visits or equivalent partial visits each Benefit Period; and
- b) are limited to a Lifetime Benefit Maximum total of one hundred-twenty (120) outpatient full-session visits or equivalent partial visits per a Member's lifetime.

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

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

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

3.17 Mental Health and Substance Abuse Services.

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

3.17.1 Mental Health Services (Members of Groups of Fifty-one (51) or more employees). All professional mental health Covered Services must be obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional. A Member may access mental health Covered Services in the following manner:

- a) as a hospital inpatient as set forth in Section 3.21.2 (b) of this Certificate;
- b) as an outpatient;
- c) pursuant to the terms and conditions of the following Riders if they are in force with the Member's Certificate:
 - 1) Non-Serious Inpatient Mental Illness Services (Mental Health Parity - Groups of 51 or More);
 - 2) Serious Mental Illness Services (Mental Health Parity - Groups of 51 or More); and/or
 - 3) Autism Spectrum Disorder Services.

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

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

- a) **Detoxification** means the process whereby an alcohol or drug intoxicated or dependent Member is assisted in a facility or by a Provider through the period of time necessary to eliminate by metabolic or other means 1) the intoxicating alcohol or drugs, 2) the alcohol and drug dependency factors or 3) alcohol in combination with drugs as determined by a Provider Physician, while minimizing the physiological risk to the Member.
- b) **Opioid** refers to natural and synthetic chemicals that have opium-like narcotic effects when ingested. Opioids include pain medications such as Vicodin™ and OxyContin™.

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

3.17.2.2.1 Cost Sharing. Each admission or covered day of a

hospital stay and related physician services, while receiving inpatient Detoxification services from a hospital which participates in the PPO's Designated Behavioral Health Benefit Program, are subject to the Preferred Provider Cost Sharing amounts specified on the Schedule of Benefits. If a Member obtains inpatient Detoxification services from a hospital which does not participate in the Designated Behavioral Health Benefit Program, the services are subject to the Non-Preferred Provider Cost Sharing specified on the Schedule of Benefits.*

3.17.3 **Short Term Acute Outpatient Opioid Detoxification Treatment.** Short Term acute outpatient opioid detoxification treatment is covered.

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

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

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

3.17.4.1 **Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.** Non-hospital residential inpatient rehabilitation for Substance Abuse is covered. The following inpatient non-hospital residential care services are covered when administered by an employee of the facility: lodging and dietary services; physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.17.4.2 **Outpatient Rehabilitation Services for Substance Abuse.** Outpatient rehabilitation services for Substance Abuse are covered. The following Outpatient facility rehabilitation services for Substance Abuse are covered when administered by an employee of the facility: physician, psychologist, nurse, certified addiction counselors and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing; drugs, medicines, equipment use and supplies.

3.17.4.3 **Partial Hospitalization.** Partial hospitalization services are covered for Substance Abuse rehabilitation. Precertification is required if partial hospitalization services are obtained from a Provider that does not participate in the Designated Behavioral Health Benefit Program,*

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

amounts specified on the Schedule of Benefits. If a Member obtains non-hospital residential inpatient rehabilitation, outpatient rehabilitation or partial hospitalization Substance Abuse services from a Provider or facility which does not participate in the Designated Behavioral Health Benefit Program, the services are subject to the Non-Preferred Provider Cost Sharing specified on the Schedule of Benefits.*

* *The use of a Provider who does not participate in the PPO's Designated Behavioral Benefit Program may subject the Member to significant out-of-pocket expense.*

3.18 Newborn Coverage. Newborn children are covered from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary hospital and physician services required by a newborn child of a Member for the treatment of medically diagnosed congenital defects and birth abnormalities (as also set forth in Section 3.25.1 of this Certificate); prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Section 6.2.3 or 8.9 of this Certificate (if applicable).

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

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

3.19.2 **Services and Supplies Necessary for the Emergency Treatment of Sound, Natural Teeth.** The need for these services must result from an accidental injury (not chewing or biting).

3.19.3 **Temporomandibular Joint (TMJ) Surgery** is limited to the following:

- a) correction of dislocation or complete degeneration of the temporomandibular Joint (TMJ);
- b) consultations to determine the need for surgery; and/or
- c) radiologic determinations of pathology.

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

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

- a) has an existing medical condition unrelated to the dental or oral surgical procedure; or
- b) has a medical condition that precludes the use of local anesthetic or in which local anesthetic is ineffective.

Such deep sedation or general anesthesia and related professional services coverage requires Precertification by the PPO.

3.20 Ostomy Supplies. The PPO will cover ostomy supplies only for Members who have had a surgical procedure which resulted in the creation of a stoma (an artificial opening in the body which remains after the surgery is completed).

3.21 Physician Services.

3.21.1 Hospital and Ambulatory Surgical Center Physician Services. The services listed in Section 3.12.1 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

- a) **Hospital.** The services set forth in Section 3.12.1 of this Certificate are Covered Services when provided by physician Providers (or other physicians in response to an emergency) or under the orders of a physician and are provided in a hospital while the Member is admitted to the hospital as a registered bed patient or is being treated as a hospital outpatient.
- b) **Ambulatory Surgical Center.** The services set forth in Section 3.12.1 of this Certificate are Covered Services when provided in an Ambulatory Surgical Center setting by physician Providers (or other physicians in response to an emergency) or under the orders of a physician.

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

- a) surgical procedures; anesthesia; and consultation with and treatment by consulting physicians; and
- b) inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in an acute hospital **EXCEPT** if the Member is an inpatient in a psychiatric unit or in a mental hospital. Inpatient psychiatric unit and mental health services by licensed psychiatrist, clinical psychologist or other licensed behavioral health professional are **NOT COVERED** except as may be explicitly provided under the terms of the following Riders:
 - i) Mental Health Inpatient and Partial Hospitalization Services;
 - ii) Non-Serious Inpatient Mental Illness Services (Groups of 50);
 - iii) Non-Serious Inpatient Mental Illness Services (Mental Health Parity – Groups of 51 or More);
 - iv) Serious Mental Illness Services (Groups of 50); and/or
 - v) Serious Mental Illness Services (Mental Health Parity – Groups of 51 or More).

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

- a) Preventive, diagnostic and treatment services listed in Section 3.22 below under **Preventive Services** in this Certificate;
- b) cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer;
- c) injectable drugs (including those injectable drugs listed in Section 3.26 of this Certificate) when determined by the Provider to be an integral part of care

rendered by the Provider during a visit, limited to the amount of drug administered during the visit. Section 2 of this Certificate sets forth the list of agents/medications requiring Precertification by the PPO;

- d) diagnostic and treatment Covered Services provided by a Specialist;
- e) Medically Necessary Covered Services upon Precertification by the PPO received from Providers who are Non-Preferred Providers when the Member's medical condition requires Covered Services that cannot be provided through Preferred Providers and/or certain procedures and services designated by the PPO. These services shall be covered at the Preferred Provider rate.

3.21.4 **Primary Care Office Visits.** Office visits for Primary Care Services are covered.

3.21.5 **Specialist Office Visits.** Office visits for specialty care services are covered.

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

3.22.1 Periodic health assessments including:

- a) medical history;
- b) physical examination, including basic ear screening examinations to determine the need for further hearing evaluation and basic eye screening examinations to determine the need for further vision evaluation;
- c) for women, an annual gynecological examination, including a pelvic examination, a clinical breast exam, chlamydia screening and a screening Pap smear in accordance with the recommendations of the American College of Obstetrics and Gynecology;
- d) annual mammogram for women forty (40) years of age and older or any mammogram based on the Provider's recommendation for women under forty (40) years of age*;
- e) DEXA scan (X-ray imaging test which measures bone density for osteoporosis); and
- f) cholesterol screening and lipid panel.

*Benefits for mammography screening are payable only if performed by a mammography service Provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

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

- a) pediatric well-child visits; and
- b) newborn screening including one (1) hematocrit and one (1) hemoglobin screening for infants under twenty-four (24) months.

3.22.3 **Pediatric and Adult Immunizations**, in accordance with accepted medical practices excluding immunizations necessary for international travel. Pediatric immunizations shall include coverage for those child immunizations, including the immunizing agents which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for

Disease Control, U.S. Department of Health and Human Services. For purposes of this subsection, child is either the Member and under twenty-one (21) years of age, or the Member's spouse and under twenty-one (21) years of age, or a Family Dependent as defined in Section 6.2 of this Certificate.

- 3.22.4 **Diabetes Care** which includes HbA1c, LDL-C and nephropathy screening tests.
- 3.22.5 **Colorectal Screening** which includes fecal occult blood testing, flexible sigmoidoscopy and colonoscopy procedures.
- 3.22.6 **Additional Preventive Care Services** as specified on the Schedule of Benefits.
- 3.22.7 **Benefit Limits.** Benefit Limits for preventive services are set forth on the Schedule of Benefits.
- 3.23 **Pulmonary Rehabilitation.** Outpatient pulmonary rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period.
- 3.24 **Rehabilitative Services.** Upon Precertification by the PPO in accordance with Section 2 of this Certificate, physical, occupational and speech therapy, on either an outpatient or inpatient basis, are covered for up to forty-five (45) dates of service per Benefit Period. This forty-five (45) day Benefit Limit is for any combination of physical, occupational and speech therapy Covered Services received within the Benefit Period. The Member should note that if more than one rehabilitative service is received on a particular day, this will only count as one day towards the forty-five (45) day limit.
- 3.25 **Restorative or Reconstructive Surgery.** Services are limited to the following:
 - 3.25.1 **Congenital Defect or Birth Abnormality.** Restorative or reconstructive surgery to correct a medically diagnosed congenital defect or birth abnormality.
 - 3.25.2 **Sickness, Accidental Injury or Incidental to Surgery.** Upon Precertification by the PPO, covered surgery performed to reasonably restore a Member to the approximate physical condition they were in prior to the defect resulting from a covered sickness, accidental injury or incidental to surgery.
- 3.26 **Select Injectable Drugs.** Subject to the terms and conditions set forth in Section 2 of the Certificate, the following injectable drugs are a Covered Service. Such injectable drugs are subject to the Cost Sharing set forth in Section 3.26.1 and on the Schedule of Benefits.
 - Amevive™ (alefacept)
 - Aldurazyme™ (laronidase)
 - Aralast™ (purified human alpha₁-proteinase inhibitor)
 - Aranesp™ (darbepoetin alfa)
 - Arranon™ (nelarabine)
 - Avastin™ (bevacizumab)
 - Boniva™ IV (ibandronate sodium)
 - Cimzia™ (certolizumab)
 - Eligard™ (leuprolide)
 - Cerezyme™ (imiglucerase)
 - Epogen™ (epoetin alpha)
 - Erbitux™ (cetuximab)
 - Fabrazyme™ (agalsidase beta)
 - Firmagon™ (degarelix)

- Flolan™ (epoprostenol)
- IVIG™ (intravenous immunoglobulin)
- Ixempra™ (ixabepilone)
- Kepivance™ (palifermin)
- Lucentis™ (ranibizumab)
- Lupron Depot™ (leuprolide acetate)
- Macugen™ (pegaptanib)
- Mozobil™ (pleriafor)
- N-Plate™ (romiplostim)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Prialt™ (ziconotide)
- Procrit™ (epoetin alpha)
- Prolastin™ (purified human alpha₁-proteinase inhibitor)
- Reclast™ (zoledronic acid)
- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Rituxan™ (rituximab)
- Simponi™ (golimumab)
- Soliris™ (eculizumab)
- Supprelin LA™ (histrelin)
- Synagis™ (palivizumab)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Trelstar™ (triptorelin)
- Tysabri™ (natalizumab)
- Velcade™ (bortezomib)
- Viadur™ (leuprolide)
- Visudyne™ (verteporfin)
- Vivaglobin™ (sub q immune globulin)
- Vivitrol™ (naltrexone injection)
- Xolair™ (omalizumab)
- Zemaira™ (purified human alpha₁-proteinase inhibitor)

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

3.27 **Skilled Nursing Facility Services.** Services are limited to the following and require Precertification by the PPO in accordance with Section 2 of this Certificate: Covered Services, including room and board on a skilled bed status, in a skilled nursing facility, is covered for the first sixty (60) days of any Period of Confinement. A Period of Confinement shall be defined as the period of time from the date of admission in a skilled nursing facility to the date of discharge. With respect to a Period of Confinement, the date of admission is counted as one (1) day and the date of discharge is not counted. If a Member is discharged from a skilled nursing facility and then readmitted for the same or a related condition within six (6) months, the second admission shall be counted as a continuation of the prior Period of Confinement.

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

3.29 Transplant Services and Authorization Requirements.

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

- (i) bone marrow (allogeneic and autologous);
- (ii) cornea (does not require Precertification);
- (iii) heart;
- (iv) heart and lung;
- (v) kidney;
- (vi) kidney and pancreas;
- (vii) liver;
- (viii) liver and kidney;
- (ix) lung (single or double);
- (x) pancreas transplant after successful kidney transplant;
- (xi) small bowel; and
- (xii) stem cell.

Members who have received a covered transplant under this Certificate may also receive coverage by the PPO's Designated Transplant Facility for certain services that would not otherwise be provided for under this Certificate.

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 are covered when Medically Necessary and performed through a Preferred Provider.

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

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

adequate information to make a determination regarding the proposed transplant procedure.

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

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

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

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

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

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

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

Covered Services provided under this Section are subject to the terms and conditions of the Riders indicated above, if applicable, and are subject to the applicable Cost Sharing specified on the Schedule of Benefits.

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.

- 3.29.9 **Retransplantation Services.** Retransplantation surgery and retransplantation-related services require Precertification by the PPO.
- 3.30 Transportation Services.** The following transportation services by land or air ambulance are covered:
- 3.30.1 **Emergency Services.** Transportation services by land or air ambulance are covered when provided in response to an emergency for a condition which meets the definition of Emergency Services as set forth under this Certificate.
- 3.30.2 **Scheduled Services.** Medically Necessary non-emergency ambulance transportation is covered.
- 3.31 Urgent Care.** Urgent Care services received through Preferred Providers in the Service Area are covered. Urgent Care services obtained from a Non-Preferred Provider outside of the Service Area are covered at the Preferred Provider rate when they are provided in response to a sudden and unexpected need for medical care while the Member is outside the Service Area which cannot be deferred until the Member's return to the Service Area.
- 3.31.1 **Cost Sharing.** The Specialist Copayment shall apply in lieu of the emergency room Copayment when a Member receives Covered Services in a designated Urgent Care facility.
- 3.32 Urological Supplies.** Urinary supplies are covered when the 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.
- 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).
- 3.34 Weight Management Program.** The PPO offers a program for weight management that includes education and management for appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. Weight management program services are covered when provided by the PPO's designated vendors. The Member should contact the Customer Service Team at the telephone number on the back of the Member's Identification Card for specific information on how to access the PPO's designated weight management program vendors.

SECTION 4. EXCLUSIONS

- 4. EXCLUSIONS. THE FOLLOWING ARE NOT COVERED by the PPO under this Certificate** unless they are specifically provided as a Supplemental Health Service under the terms of a Rider (all of which are listed on a Member's Schedule of Benefits). If a Member does not have a Rider covering a service listed in this Section and he or she receives the service, the Member will be financially responsible for all charges or fees associated with the service.
- 4.1 Acupuncture.** Acupuncture is **NOT COVERED**.
- 4.2 Any Cost for Covered Services That Exceeds the Lifetime Benefit Maximum.** Any cost for Covered Services that exceeds the Lifetime Benefit Maximum is **NOT COVERED**.
- 4.3 Any Cost for Services Obtained From Non-Preferred Providers That Exceeds the PPO's Then Current Non-Preferred Provider Fee Schedule Amount.** Any cost for services obtained from Non-Preferred Providers that exceeds the PPO's then current Non-Preferred Provider Fee Schedule Amount is **NOT COVERED**, except with respect to Emergency Services as set forth in Section 3.7.2 of this Certificate or when Covered Services are not available from a Preferred Provider.
- 4.4 Batteries Required for Diabetic Medical Equipment.** Batteries required for diabetic medical equipment are **NOT COVERED**.
- 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**, except as provided in Certificate Sections 3.16 and 3.17. If a Member has coverage under the Autism Spectrum Disorder Services Rider, and requires services under such Rider, the terms and conditions of such Rider will determine the behavioral services available for the Member.
- 4.6 Biofeedback.** Biofeedback is **NOT COVERED**.
- 4.7 Blood or Other Body Tissue and Fluids, Including Storage.** Blood and its components or any artificially created blood products are **NOT COVERED**. Storage of blood, including autologous and cord blood, other body tissue and fluids is **NOT COVERED**.
- 4.8 Breast Surgery.** Surgery for male or female breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 of this Certificate.
- 4.9 Charges Covered under Certain Acts or Laws.** Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law are **NOT COVERED**. This exclusion applies regardless of whether the Member claims the benefit compensation.
- 4.10 Complications Resulting from a Non-Covered Procedure or Service.** If a Member receives a procedure or service (including but not necessarily limited to Cosmetic Surgery) which is not a Covered Service under this Certificate and the Member has a physical or medical complication in conjunction with, or as a result of, the procedure or service, services related to such complications are **NOT COVERED**.

- 4.11 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 under the terms of the following Rider: Eyewear.
- 4.12 Cosmetic Surgery.** Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO, is **NOT COVERED**. This exclusion does not apply to Covered Services set forth in Sections 3.14, 3.25.1 or 3.25.2 of this Certificate.
- 4.13 Custodial, Convalescent or Domiciliary Care.** Custodial, Convalescent or Domiciliary Care services are **NOT COVERED**.
- 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, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the PPO will cover expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.19.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth) or as may be explicitly provided under the terms of the following Rider: Impacted Wisdom Teeth.
- 4.15 Drug Maintenance Programs.** Drug maintenance programs for the outpatient treatment of drug detoxification, dependency or addiction are **NOT COVERED**. This drug maintenance program exclusion includes, but is not limited to, the use of the drugs Suboxone™ and Subutex™ or their generic equivalents in an outpatient Drug Maintenance Program unless there is an Outpatient Prescription Drug Rider listed on the Schedule of Benefits as being in place with this Certificate. If such a Rider is in place with this Certificate, Suboxone™ and Subutex™ may be administered according to the terms and conditions of the Rider and Certificate Sections 3.16.3 through and including 3.16.3.2, (as applicable) or 3.17.3 through and including 3.17.3.2, (as applicable).
- 4.16 Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate in Sections 3.3.3 and 3.29.7 or as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider or an Autism Spectrum Disorder Services Rider if such Riders are listed on the Schedule of Benefits as being in place with this Certificate.
- 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 an Outpatient Prescription Drug Rider with Contraceptive coverage if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.
- 4.18 Elective Abortions.** Abortions are **NOT COVERED** except for those that are Medically Necessary for the life or physical health of the mother, or to terminate pregnancy caused by rape or incest.
- 4.19 Experimental, Investigational or Unproven Services.** Experimental, investigational or unproven services are **NOT COVERED**.
- 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 Section 2.3 of this Policy, **Designated Procedures and Services Requiring Precertification.**
- 4.21 Foot Care Services.** Except for Members with diabetic conditions, the treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet and chronic foot strain are **NOT COVERED.**
- 4.22 Gender Reassignment.** Transplants, implants, procedures, services and supplies related to gender reassignment are **NOT COVERED.**
- 4.23 Government Responsibility.** Care for military service related disabilities if the care is being provided in a U.S. Military Facility for which the Member does not incur a legal responsibility to pay for such care is **NOT COVERED.**
- 4.24 Government-Sponsored Health Benefits Program.** Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are **NOT COVERED.** All required Precertifications must be obtained even when the PPO is the secondary carrier.
- 4.25 Hair Removal.** Hair removal is **NOT COVERED.**
- 4.26 Hypnosis.** Hypnosis is **NOT COVERED.**
- 4.27 Illegal Activity.** Covered Services required as a result of a Member's commission of or attempt to commit a felony or being engaged in an illegal occupation, are **NOT COVERED.**
- 4.28 Infertility Procedures.** In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), embryo transplants, artificial insemination and similar procedures as determined by the PPO are **NOT COVERED.** Expenses incurred or Covered Services required for any infertility procedures resulting from a Member's or a Member's spouse's voluntary sterilization are **NOT COVERED.** Sperm, ova and embryo storage are **NOT COVERED.**
- 4.29 Insertion and Removal of Non-Covered Implanted Devices.** Any costs, charges or fees associated with the insertion, fitting or removal of an implanted device, when such device is not covered under the terms of this Certificate, are **NOT COVERED.**
- 4.30 Insured Obligations.** Any amounts for a Covered Service which are greater than the PPO's then current Non-Preferred Provider Fee Schedule Amount (except with respect to costs associated with Emergency Services) or which exceed the Lifetime Benefit Maximum set forth on the Schedule of Benefits, or amounts for any Covered Service which are applied toward satisfaction of the Deductible, Copayment or Coinsurance amounts, or which exceed the specific Benefit Limits set forth on the Schedule of Benefits are **NOT COVERED.**
- 4.31 Manipulative Treatment Services.** Manipulative treatment services are services rendered for the treatment or diagnosis of neuromusculoskeletal disorders and are **NOT COVERED** except as may be explicitly provided under the terms of the following five Riders:
- a) Manipulative Treatment American Specialty Health Networks (ASH Networks);
 - b) Manipulative Treatment (Out-of-Service Area) American Specialty Health Networks (ASH Networks);
 - c) Manipulative Treatment Services Enhanced Option American Specialty Health Networks (ASH Networks);

- d) Manipulative Treatment Services Enhanced Option (Out-of-Service Area) American Specialty Health Networks (ASH Networks); and/or
- e) Manipulative Treatment Services.

4.32 Mental Health Inpatient Professional Services. Mental health inpatient professional services provided by a licensed psychiatrist or clinical psychologist are **NOT COVERED** unless expressly set forth in Section 3.21.2 of this Certificate, or except as may be explicitly provided under the terms of the following Riders:

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

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

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

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

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

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

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

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

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

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

- 4.40 Orthoptic Therapy.** Orthoptic therapy (vision exercises) is **NOT COVERED**.
- 4.41 Panniculectomy, Lipectomy and Abdominoplasty.** Excision of excessive skin and subcutaneous tissue including but not limited to panniculectomy, abdominoplasty or lipectomy by any method (such as suction assisted liposuction or aspiration) is **NOT COVERED**. These procedures may involve areas such as, but not limited to, head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks and hips.
- 4.42 Personal Comfort Items/Services.** Personal comfort items and services including but not limited to, telephones, televisions and special meals are **NOT COVERED**.
- 4.43 Prescription Drug Use by a Non-Member.** Use by anyone other than the Member of a Prescription Drug, device or equipment provided to a Member according to the terms and conditions set forth in Section 3, **Covered Services**, of this Certificate or any applicable Riders, is **NOT COVERED**.
- 4.44 Prescription Bandages and Wound Dressings.** Prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in Section 3.20 of this Certificate.
- 4.45 Private Duty Nursing.** Hourly nursing care on a private duty basis is **NOT COVERED**.
- 4.46 Refraction Examinations.** Examinations to determine the refractive errors of the eye are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider: Refractions.
- 4.47 Refractive Procedures.** Any surgery to correct the refractive error of the eye is **NOT COVERED**.
- 4.48 Reversal of Sterilization.** Surgical procedures to reverse voluntary sterilization are **NOT COVERED**.
- 4.49 Revision of the External Ear.** Revision of the external ear is **NOT COVERED**.
- 4.50 Riot or Insurrection.** Covered Services required as a result of a Member's participation in a riot or insurrection, are **NOT COVERED**.
- 4.51 Routine Nail Trimming.** Routine nail trimming is **NOT COVERED**.
- 4.52 Services Provided by a Member's Relative or Self.** Services rendered by a physician Provider who is the spouse, child, parent, grandparent, aunt, uncle, niece or nephew, sibling or persons who ordinarily reside in the household of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.
- 4.53 Services Related to or Required by a Non-Covered Service.** Any service related to or required by a non-Covered Service, including but not limited to anesthesia or diagnostic services, is **NOT COVERED**.
- 4.54 Sexual Dysfunction Services, Devices and Equipment.** Sexual dysfunction services, devices and equipment, male or female, are **NOT COVERED**.
- 4.55 Transportation Services.** Stretcher/wheelchair van transportation or transportation services that are not Medically Necessary are **NOT COVERED**.

- 4.56 Vein Sclerosing.** Injection of sclerosing solution into superficial veins (commonly called spider veins) is **NOT COVERED**. Injection of sclerosing solution into varicose leg veins is **NOT COVERED** unless Medically Necessary.
- 4.57 Weight Control.** Weight management programs for non-morbid obesity are **NOT COVERED** unless as provided for in Section 3.34 of this Certificate.
- 4.58 THE FOLLOWING SERVICES ARE NOT COVERED WHEN OBTAINED FROM NON-PREFERRED PROVIDERS:**
- 4.58.1 **Diabetic Medical Equipment, Blood Glucose Monitors, Diabetic Foot Orthotics, Insulin and Oral Pharmacological Agents for Controlling Blood Sugar, Disposable Syringes and Blood Glucose Monitor Supplies (Lancets and Blood Glucose Test Strips) and Outpatient Training and Education.** Diabetic medical equipment, blood glucose monitors, foot orthotics, insulin and oral pharmacological agents for controlling blood sugar, disposable syringes, blood glucose monitor supplies (lancets and blood glucose test strips) and outpatient training and education are **NOT COVERED**.
- 4.58.2 **Enteral Feedings/Food Supplements.** Enteral feedings/food supplements obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.3 **Foot Care Services.** Foot Care services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.4 **Genetic Counseling and Testing.** Genetic counseling and testing obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.5 **Mental Health or Substance Abuse Services Obtained From a Provider Who Does Not Participate in the PPOs Designated Behavioral Health Benefit Program.** Mental health or Substance Abuse services obtained from a Provider who does not participate in the PPO's Designated Behavioral Health Benefit Program are **NOT COVERED**.
- 4.58.6 **Obesity Surgery Performed by Non-Preferred Providers.** Obesity surgery performed by Non-Preferred Providers is **NOT COVERED**.
- 4.58.7 **Organ, Bone Marrow, Stem Cell or Corneal Transplants, Evaluation and Related Services.** Organ, bone marrow, stem cell or corneal transplants, evaluation and related services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.8 **Pain Management.** Pain management services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.59 THE FOLLOWING DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC DEVICES AND PROSTHETIC DEVICES ARE NOT COVERED:**
- 4.59.1 **Access Ramps** for home or automobile are **NOT COVERED**.
- 4.59.2 **Anodyne Infrared Therapy.** Anodyne infrared therapy is **NOT COVERED**.
- 4.59.3 **Batteries** for DME, Orthotic Devices and/or Prosthetic Devices are **NOT COVERED**.

- 4.59.4 **Cold Therapy and/or Ice Packs.** Continuous hypothermia machine cold therapy and/or ice packs are **NOT COVERED**.
- 4.59.5 **Computerized Devices and Communicative Equipment.** Communicative equipment or devices, computerized assistive devices and communication boards are **NOT COVERED**.
- 4.59.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** of any sort, except for diabetic foot orthotics which are covered as a Covered Service under Section 3.3.2 of this Certificate, are **NOT COVERED**.
- 4.59.7 **Dental Appliances** of any sort including, but not limited to, bridges, braces and retainers are **NOT COVERED**.
- 4.59.8 **Disposable Supplies** which include but are not limited to, gloves, ace bandages, self-administered catheters, spacer devices for meter dose inhalers, peak flow meters or incentive spirometers are **NOT COVERED**.
- 4.59.9 **Exercise Equipment or Facilities.** Exercise equipment such as whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools and saunas are **NOT COVERED**.
- 4.59.10 **Experimental or Research Equipment** which, as determined by the PPO, is not accepted as Standard medical treatment of the condition being treated, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device, Orthotic Device or DME was provided is **NOT COVERED**. The experimental or non-experimental nature of any Prosthetic Device, Orthotic Device, or DME shall be determined by the PPO in accordance with the terms and conditions set forth in Section 1.24 of this Certificate.
- 4.59.11 **Home Monitoring Equipment** is **NOT COVERED**, except for apnea monitors and pulse oximeters which are covered for Members age seventeen (17) and younger.
- 4.59.12 **Items for Personal Comfort or Convenience.** Items which are primarily for personal comfort or convenience, including but not limited to bed boards, air conditioners and over-bed tables are **NOT COVERED**.
- 4.59.13 **More than One Piece of Equipment** that serves the same function, including rental or back up of owned or rented equipment is **NOT COVERED**.
- 4.59.14 **Motor Driven or Deluxe Equipment** of any sort is **NOT COVERED**.
- 4.59.15 **Motor Vehicles or Vehicle Modifications.** Motor vehicles, or any modification to a motor vehicle (including but not limited to car seats) are **NOT COVERED**.
- 4.59.16 **No Longer Medically Necessary.** Any piece of equipment which is determined by the PPO to be no longer Medically Necessary is **NOT COVERED**.
- 4.59.17 **Non-Medical Self-help Devices.** Self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides are **NOT COVERED**.

- 4.59.18 **Non-Preferred Provider.** Unless approved in advance by the PPO, DME, Prosthetic Devices and/or Orthotic Devices which are obtained from a Non-Preferred Provider are **NOT COVERED**.
- 4.59.19 **Non-Standard Equipment or Devices.** Deluxe Equipment or devices of any sort, which has been otherwise determined by the PPO to be non-Standard is **NOT COVERED**.
- 4.59.20 **Repair or Replacement** of any piece of equipment/device, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in Section 3.6.2 of this Certificate.
- 4.59.21 **Replacement of Component Parts or Modification** of a Standard Prosthetic Device unless incident to the Member's growth for a Member who is under the age of nineteen (19) years as set forth in Section 3.6.4.1 of this Certificate is **NOT COVERED**.
- 4.59.22 **Specifically Listed Items, Devices and Equipment.** The following are **NOT COVERED**:
- a) breast pumps;
 - b) hairpieces and wigs;
 - c) seasonal affective disorder lights;
 - d) air filtration units;
 - e) vaporizers;
 - f) heating lamps;
 - g) pads, pillows and/or cushions;
 - h) hypoallergenic sheets;
 - i) paraffin baths;
 - j) vitrectomy face support devices; and
 - k) safety equipment (including but not limited to: gait belts, harnesses and vests).

SECTION 5. APPEAL PROCEDURE

5. **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 Choice 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.

A Pre-Service, Post-Service or Urgent Care Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, will be reviewed by a PPO Medical Director who did not previously participate in any prior decision relating to the appeal and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination. The PPO Medical Director will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. The review will include the input of a licensed physician or licensed psychologist in the same or similar specialty that typically manages, treats or consults on the health care service or condition.

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 60 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.** A Pre-Service Appeal shall be reviewed by a committee that consists of one (1) or more PPO employees or designees who did not previously participate in any prior decision relating to the Pre-Service Appeal and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination.

5.1.2 **Pre-Service Appeal of any Adverse Benefit Determination.** A Pre-Service Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by a PPO Medical Director who did not previously participate in any prior decision relating to the appeal and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination. The PPO Medical Director will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. The review will include the input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages, treats or consults on the health care service or condition.

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; and
- d) the notification of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

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.** A Post-Service Appeal shall be reviewed by a committee that consists of one (1) or more PPO employees or designees who did not previously participate in the Adverse Benefit Determination and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination. The committee will consider the full record of the Post-Service Appeal and make a determination independent of previous reviewers.

5.2.2 **Post-Service Appeal of any Adverse Benefit Determination.** A Post-Service Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, will be reviewed by a PPO Medical Director who did not previously participate in any prior decision relating to the appeal and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination. The PPO Medical Director will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. The review will include the input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages, treats or consults on the health care service or condition.

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 sixty (60) days after receipt of the written request. The PPO shall provide the Member with written notification of the PPO's decision no later than sixty (60) 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; and
- d) notification of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

5.3 **Urgent Care Appeal Procedure.** An Urgent Care Appeal is a request to change an Adverse Benefit Determination for Urgent Care for Covered Services. An Urgent Care Appeal is any request for medical care or treatment with respect to the application of the time-periods for making non-Urgent Care determinations:

- a) which could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on the judgment of a prudent layperson who possesses average knowledge of health and medicine; or
- b) in the opinion of a practitioner with knowledge of the Member's medical condition, delay occasioned by the time-periods for making a non-Urgent Care determination would subject the Member to severe pain that cannot be adequately managed without the care or treatment being requested.

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.** An Urgent Care Appeal will be reviewed by a PPO Medical Director who did not previously participate in any prior decision relating to the appeal and shall not be a subordinate of the person(s) who made the initial Adverse Benefit Determination. A decision shall be made within seventy-two (72) hours after receipt of the request for an Urgent Care Appeal. The Medical Director will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. The review will include the input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages, treats or consults on the health care service or condition. 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 of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

SECTION 6. ELIGIBILITY

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

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

- a) a Member for whom payment has actually been received by the PPO; and
- b) a bona fide (one who may legally work in the United States) employee of a Group or member of a union entitled to participate in a health benefits program arranged by the Group or be entitled to coverage under a trust agreement and have satisfied any probationary or waiting period established by the Group; or
- c) a former bona fide employee or member of a union, or the dependent of a former bona fide employee or member of a union, entitled under COBRA or other law, or as otherwise set forth in the Group Master Policy, to participate in a program of health benefits arranged by the Group.

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

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

- a) the spouse of a Subscriber; or
- b) an unmarried dependent child, whose age is less than the Maximum Age for dependent children as stated on the Schedule of Benefits.

6.2.1 A dependent child is defined as:

- a) a natural child,
- b) an adopted child,
- c) a natural child or an adopted child of the Subscriber or the Subscriber's spouse, for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order, or
- d) any other child of whom the Subscriber or the Subscriber's spouse is the Legal Guardian, custodial parent or Legal Custodian. The PPO may periodically require documentary proof of such dependency.

Eligibility shall cease for a dependent child who (i) reaches the Maximum Age, as set forth in the Group Master Policy; (ii) becomes married; or (iii) obtains full-time employment (except for disabled dependent children and students). Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage.

6.2.2 New Spouse. A newly married Subscriber may arrange for Family Coverage by enrolling his or her spouse in the PPO within thirty-one (31) days of marriage. Coverage of the spouse under this Certificate shall be effective as of the date of marriage if the Subscriber's coverage was in effect on that date. Premiums for such

continued coverage of a spouse shall be payable from the date of marriage. No Evidence of Insurability shall be required.

6.2.3 **Newborn Child.** A newborn child of a Member is automatically covered under this Certificate for thirty-one (31) days from the date of birth. To continue coverage of a newborn, a request for addition to Family Coverage (or a change from single to Family Coverage) must be submitted to the PPO within thirty-one (31) days of the date of birth and all premium requirements shall be paid. No Evidence of Insurability shall be required.

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

An adopted child or a child placed for adoption with the Subscriber is automatically covered under this Policy 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 thirty-one (31) days of the date of adoption or date the child was placed for adoption with the Subscriber. 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. No Evidence of Insurability shall be required.

6.2.5 **Children Born To Family Dependents.** A child born to a Family Dependent is automatically covered under this Certificate for thirty-one (31) days from the date of birth. To continue coverage of such child, the Subscriber must submit a request for addition to Family Coverage to the PPO within thirty-one (31) days of the date of birth and pay the required premium.

6.2.6 **Continued Coverage of Disabled Dependent Child.** An unmarried dependent child who exceeds the Maximum Age for dependent children and is:

- a) incapable of self-sustaining employment by reason of disability resulting from mental retardation or a physical disability which meets the criteria under §88.41 of Title 31, PA Code and who became so prior to the attainment of age nineteen (19); and
- b) is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance, may continue enrollment or will become eligible for enrollment under Family Coverage for the duration of such disability and dependency.

In addition, such unmarried dependent child must have been enrolled as a Family Dependent under this Certificate prior to reaching the age of nineteen (19) or under the terms of another Group health benefit program offered by the Group as an alternative to the PPO. 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.

6.2.7 **Students.** The Schedule of Benefits gives two (2) Maximum Ages for dependent children: one (1) for dependent children who are full-time students and one (1) for all other dependent children. The full-time student Maximum Age shall apply to an individual who is either a high school student or enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study. The 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.

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

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

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

- (i) submit a form approved by the Department of Military and Veterans Affairs notifying the PPO that the full-time student has been placed on active duty;
- (ii) submit a form approved by the Department of Military and Veterans Affairs notifying the PPO that the full-time student is no longer on active duty;
- (iii) submit a form approved by the Department of Military and Veterans Affairs showing that the full-time student has reenrolled as a full-time student for the first term or semester starting sixty or more days after his or her release from active duty.

6.2.7.2 **Continuing Coverage of Full-Time Students on Medical Leave.** Federally enacted Michelle’s Law extends coverage to dependent full-time students over the age of eighteen (18) who are enrolled in an institution of higher education and who would otherwise lose health care coverage if a Medically Necessary leave of absence causes them to fall below full-time student status. To continue the student’s coverage, the PPO must be provided with a physician’s written certification of the

student's serious illness or accident citing the Medical Necessity of the leave. Such coverage will be provided by the PPO for: a) up to one year after the first day of the leave of absence or b) the date the student's coverage would otherwise terminate under the terms and conditions of the Certificate; whichever date comes earlier. Under Michelle's Law regulations, the student will receive the same coverage as the Subscriber and other Family Dependents under the Certificate.

6.2.8 Noncustodial Children. A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order. The Subscriber must make written application for membership of such child. The PPO will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty (30) days of receipt by the Plan of said official court order. The Subscriber shall notify the 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. 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.

6.3 Continued Eligibility During Military Service. If a Subscriber is called to Active Military Duty (for the purpose of this Section only, Active Military Duty is defined as voluntary or involuntary duty in a uniformed service under competent authority), coverage will continue under the PPO for the first thirty (30) days of the Active Military Duty. After the expiration of the first thirty (30) days, the Subscriber will be given the option of continuing health care coverage at their own expense through a COBRA or Mini-COBRA offering, as applicable, for themselves and their eligible Family Dependents. This offering will be at the same rate paid by the employer for the Subscriber's and the Subscriber's eligible Family Dependents' coverage. The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.23 of this Certificate.

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

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

- a) have ceased eligibility under the terms and conditions of the Certificate due to a qualifying event, as defined under COBRA; and
- b) have properly elected to receive COBRA coverage.

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

specific information on how to elect COBRA coverage and the associated costs of such coverage. Premiums for COBRA coverage will be remitted to the PPO by:

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

6.4.1 **Post-COBRA Conversion Coverage.** A Subscriber and/or eligible Family Dependents shall be entitled to obtain a conversion policy upon termination of COBRA coverage according to the terms and conditions set forth in Section 8.6.8 of this Certificate.

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

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

- a) have been continuously insured under the Certificate or insured for similar benefits under any group policy which it replaced, during the entire three (3) month period ending with the Member's termination;
- b) have ceased eligibility under the terms and conditions of the Certificate due to the occurrence of a qualifying event as defined under Mini-COBRA;
- c) are not covered by or eligible for coverage under Medicare;
- d) are not covered or eligible to be covered under any other insured or uninsured group health insurance coverage under which the Member was not covered immediately prior to termination (excludes Medical Assistance, CHIP and adultBasic);
- e) can verify he or she is ineligible for employer based group insurance as an eligible dependent; and
- f) have properly elected to receive Mini-COBRA coverage.

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

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

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

6.5.2 **Post Mini-COBRA Conversion Coverage.** A Subscriber and eligible dependents shall be entitled to obtain a conversion policy upon termination of Mini-COBRA coverage according to the terms and conditions set forth in Section 8.6.8 of this Certificate.

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

- a) submitted a properly completed Enrollment Application listing the Subscriber and all Family Dependents (regardless of whether they will be enrolled) to the Group;
- b) enrolled all Family Dependents or declined coverage in writing for any Family Dependents eligible to be enrolled; and
- c) paid the applicable monthly premium for coverage under the terms and conditions of this Certificate.

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

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

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

- a) newly married spouses, newborns, adopted children, children placed for adoption or children born to Family Dependents, whose dates of coverage are established by law; and
- b) as otherwise set forth in the Group Master Policy when the Group Master Policy is modified by the Group.

6.6 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the PPO by submitting a completed Enrollment Application on forms provided by the PPO (or provided by the Group if approved by the PPO). No eligible person will be refused enrollment within thirty-one (31) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a Special Enrollment Period. No Evidence of Insurability shall be required. The Group shall comply with the PPO's underwriting requirements.

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

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

- a) the individual was actually enrolled for benefits under the other program at the time he first became eligible for enrollment in the PPO;
- b) the individual declined enrollment, in writing, for himself and any family dependent, stating that the coverage under the other group health plan was the reason for declining enrollment;
- c) the individual was enrolled in the other program during the most recent Open Enrollment Period, if eligible for enrollment in the PPO at that time;
- d) loss of eligibility under the other program was as a result of
 - i) termination of employment,
 - ii) reduction in the number of hours of employment,
 - iii) termination of the other program's coverage,
 - iv) termination of contributions toward the premium made by the Group,
 - v) death of a spouse, divorce, or legal separation,
 - vi) expiration of the COBRA or Mini-COBRA continuation of Benefit Period (for COBRA and Mini-COBRA eligible Groups),
 - vii) no longer working or residing in the service area when the other program (such as an HMO) does not provide benefits to an individual who no longer works or resides in the service area, or
 - viii) meeting or exceeding a lifetime limit on all benefits under the other program; **AND**
- e) application for enrollment in the PPO is made within thirty-one (31) days of the last date of eligibility under the other program.

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

- a) An individual or dependent who was covered under a state Medicaid or CHIP plan had their coverage terminated as a result of the loss of eligibility for such coverage. Such individual or dependent must request coverage by the PPO not later than sixty (60) days after the termination of coverage under the state Medicaid or CHIP program.
- b) An individual or dependent has become eligible for a premium assistance subsidy for the PPO under a state Medicaid or CHIP plan. Such individual or dependant must request coverage under the PPO not later than sixty (60) days after the individual or dependent is determined to be eligible for such assistance.

6.8 Pre-Existing Condition Exclusion. Coverage for Pre-Existing Conditions shall begin after the Member has been covered under the PPO for twelve (12) months. This exclusion applies to all services, with the exception of those set forth in this Certificate. The Pre-Existing

Condition exclusion shall begin from the date of enrollment under the Certificate and credit shall be given for the time the Member had Creditable Coverage as set forth in Section 6.8.2. To the extent that this Certificate replaces another group contract, the PPO shall only apply a Pre-Existing condition exclusion if excluded by the other group policy.

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

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

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

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

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

6.11 Notice of Ineligibility. It shall be the Subscriber's responsibility to notify the Group or the 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 thirty-one (31) days of the event.

SECTION 7. PAYMENT PROVISIONS

7. PAYMENT PROVISIONS.

- 7.1 Payment of Premiums.** The monthly premiums for coverage are specified in the Group Master Policy, as amended from time to time. The Group or its agent on behalf of a Subscriber shall make payment of such premium for coverage under this Certificate. Premium shall be remitted on a monthly basis to the PPO within the specified time frames set forth in this Certificate or as otherwise set forth in the Group Master Policy. Only a Member for whom the premium is actually received by the PPO shall be entitled to coverage under this Certificate and only for the month for which such premium is received.
- 7.2 Adjustment of Premiums.** The monthly premiums shall be effective until the renewal date of the Group Master Policy and shall be subject to revision thereafter as of each renewal date of the Group Master Policy, or such other date as the Group and the PPO may specify. The PPO will notify the Group of any adjustment to premium as set forth in the Group Master Policy. Notice of adjustment of a premium, or adjustment of the Subscriber's contribution to the premium as required by the Group, will be provided by the Group to the Subscriber. Premium changes may be subject to review and approval by the Pennsylvania Department of Insurance.
- 7.3 Time of Payment.** In order for benefits to be provided, the premium must be paid on or before the first day of the effective coverage month for each Member under this Certificate or as specified in the Group Master Policy, subject to the grace period provisions specified in this Certificate. The first monthly premium must be paid in full on or before the due date indicated on the first premium statement.
- 7.4 Grace Period.** If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within thirty (30) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 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.

SECTION 8. GENERAL PROVISIONS

8. GENERAL PROVISIONS.

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

8.2 Coordination of Benefits.

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

- a) **Program** is any of the following programs of health benefits coverage that provides medical care or treatment benefits or services to their Members:
 - i) group health benefits coverage, whether insured or uninsured;
 - ii) coverage under a governmental health benefits program or a program required by law. This does not include a state program under Medicaid (Title XIX, Grants to States for Medical Assistance programs of the United States Social Security Act, as amended from time to time).

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

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

- b) **This Plan** is the portion of this Certificate that provides Covered Services to Members and is subject to this COB provision.
- c) **Primary Plan** and **Secondary Plan.** The following Order of Benefit Determination Rules state whether This Plan is Primary or Secondary relative to another Program covering the Member:
 - i) When This Plan is Primary, its benefits are provided without consideration for the other Program's benefits;
 - ii) When This Plan is Secondary, its benefits may be reduced and it may recover from the Primary Plan the reasonable cash value of the Covered Services provided by This Plan.
- d) **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one (1) or more Programs covering the Member for whom the claim is made. The term Allowable Expense does not include coverage for items **NOT COVERED** under this Certificate. When This Plan provides Covered Services, the reasonable cash value of each service is the Allowable Expense and is

considered a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the Member's stay in a private hospital room is Medically Necessary.

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

8.2.2 **Applicability.**

- a) If the Member is covered by This Plan and another Program, the Order of Benefit Determination Rules described below determine the Primary Plan/Secondary Plan. The benefits of This Plan:
 - i) shall not be reduced when, under the Order of Benefit Determination Rules, This Plan is Primary, but;
 - ii) may be reduced or the reasonable cash value of any Covered Service provided by This Plan may be recovered from the Primary Plan when, under the Order of Benefit Determination Rules, another Program is Primary. The above reduction is more fully described below.

8.2.3 **Order of Benefit Determination Rules.**

- a) **General.** When a Member receives Covered Services by or through This Plan, or is otherwise entitled to claim benefits from This Plan, and the Covered Services are the basis for a claim under another Program, This Plan is a Secondary Plan which has its benefits determined after those of the other Program, unless: i) the other Program has rules coordinating its benefits with those of This Plan; and ii) both the other Program and This Plan's rules in subparagraph (b) below, require that This Plan's benefits be determined before those of the other Program.
- b) **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
 - 1) **Non-Dependent/Dependent.** The benefits of the Program which covers the Member as a Subscriber are Primary to those of the Program which covers the Member as a Family Dependent.
 - 2) **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph (b) (3) below, when This Plan and another Program cover the same child as a Family Dependent of different persons called "parents":
 - i) the Program of the parent whose birthday falls earlier in a year is Primary to the Program of the parent whose birthday falls later in that year, but;
 - ii) if both parents have the same birthday, the Program which covered a parent longer is Primary. However, if the other Program does not have the rule described in (i) immediately above, but instead has a rule based on the gender of the parent and if as a result the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

- 3) **Dependent Child/Separated or Divorced Parents.** If two (2) or more Programs cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - i) first, the Program of the parent with custody of the child;
 - ii) then, the Program of the spouse of the parent with custody of the child; and
 - iii) finally, the Program of the parent not having custody of the child; or
 - iv) if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Program obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Program is Primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Program year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- 4) **Active/Inactive Employee.** A Program which covers a Member as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary to a Program which covers that Member as a laid off or retired employee (or that employee's dependent) and further subject to this Section. If the other Program does not have this rule, and if as a result, the Programs do not agree on the order of benefits, this rule (4) is ignored.
- 5) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Program which covered a Member longer is Primary to the Program which covered that Member for a shorter time.

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

- a) This Section applies when, under the above Section of the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one (1) or more other Programs. In such event, the benefits of This Plan may be reduced under this Section.
- b) **Reduction in This Plan's Benefits.** This Plan may reduce benefits payable or may recover the reasonable cash value of the Covered Services when the sum of the following exceeds those Allowable Expenses in a Claim Determination Period:
 - i) the benefits that would be payable for, or the reasonable cash value of the Covered Services under This Plan in the absence of this COB provision; and
 - ii) the benefits that would be payable as Allowable Expenses under the other Programs, in the absence of similar provisions like this COB provision, whether or not claim is made.

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

- 8.2.5 **Right to Receive and Release.** Certain information is needed to apply these COB rules. This Plan has the right to decide which information it needs. This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this. Each person claiming benefits under This Plan must give This Plan any information it needs.
- 8.2.6 **Facility of Payment.** A payment made or a service provided under another Program may include an amount which should have been paid or provided under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a payment under This Plan.
- 8.2.7 **Right of Recovery.** If the amount of the payment made by This Plan is more than it should have paid under this COB provision, or if it has provided Covered Services which should have been paid by the Primary Plan, This Plan may recover the excess or the reasonable cash value of the Covered Services as applicable, from one or more of:
- a) the persons it has paid or for whom it has paid;
 - b) insurance companies; or
 - c) other organizations.
- 8.2.8 **Provisions of Covered Services.** This Plan shall provide health services first and then seek Coordination of Benefits.
- 8.2.9 **Medicare and Worker's Compensation.**
- 8.2.9.1 **Coordination of Benefits with Medicare.** The following sections set forth whether this PPO is primary or secondary in regard to Medicare coverage for the Subscriber who is age sixty five (65) or older. If the PPO is **primary**, the PPO will pay for Covered Services and Medicare will pay for Medicare eligible expenses, if any, not paid by the Plan. If the PPO is **secondary**, Medicare will pay for Medicare eligible expenses first and the PPO will pay for Covered Services, if any, not paid for by Medicare. For the purpose of this Section, the term Subscriber includes all Family Dependents who are age 65 or older.
- a) This PPO is **primary** to Medicare when the Subscriber is age sixty five (65) or older, is Medicare eligible, is defined as an Active Employee by Medicare regulations and is working for an employer with twenty (20) or more employees.
 - b) This PPO is **primary** to Medicare when the Subscriber is under age sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability (other than ESRD described below) and is an Active Employee (defined by Medicare regulations) working for an employer with at least one hundred (100) employees.
 - c) This PPO is **secondary** to Medicare when the Subscriber is age sixty five (65) or older, is Medicare eligible and is working for an employer with less than twenty (20) employees.

- d) This PPO is **secondary** to Medicare when the Subscriber is age sixty five (65) or older, is retired and is covered with retiree group coverage under the PPO.
- e) This PPO is **secondary** to Medicare when the Subscriber is under the age of sixty five (65), becomes disabled and entitled to Medicare benefits due to such disability, is an Active Employee (defined by Medicare regulations) and works for an employer with less than one hundred (100) employees.
- f) If the Subscriber has End Stage Renal Disease (ESRD) the PPO will be primary for the first thirty (30) months of the Subscriber's entitlement to Medicare (as defined by Medicare regulations). After the first thirty (30) months, Medicare will become the primary coverage. However, if the PPO is currently providing benefits as the secondary provider when the Subscriber becomes entitled to ESRD Medicare benefits, the PPO will remain the secondary provider. The same conditions apply as indicated above in regard to ESRD if the Subscriber has COBRA coverage under the PPO.

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

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

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

TERM AND TERMINATION.

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

8.5 Termination by the Group. The Group may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the Group shall result in the individual rights to benefits and Covered Services awarded under this Certificate ceasing on the effective date of termination, except as set forth in Section 8.9.

8.6 Termination by the PPO. The PPO may terminate this Certificate for the following reasons:

8.6.1 Failure to Pay.

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

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

8.6.2 Fraud or Material Misrepresentation.

8.6.2.1 **By the Group.** In the event the Group makes an intentional misrepresentation for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. This decision may be appealed through the 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 material fact in the application for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to

the Subscriber and the Group. This decision may be appealed through the PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

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

- 8.6.3 **Failure to Continue to Meet the Group Eligibility Requirements.** If a Member ceases to meet the Group eligibility requirements, coverage shall terminate subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber.
- 8.6.4 **Termination of Group Master Policy.** The PPO may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the PPO means that individual rights to benefits and Covered Services awarded under this Certificate cease on the effective date of termination. If a Member whose coverage was terminated pursuant to this Section has succeeding or alternate carrier health service coverage, they are not eligible for conversion to individual, direct payment coverage where there is a succeeding or alternate carrier. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 8.9 of this Certificate.
- 8.6.5 **Subscriber's Death.** In the event of the death of a Subscriber, coverage shall terminate for his enrolled Family Dependents on the last day of the period for which payments have been made by, or on behalf of such Subscriber, subject to the conversion privilege set forth below. Surviving Family Dependents may also be eligible to continue Group coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 8.9.
- 8.6.6 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage with respect to the child subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber. This decision may be appealed through the PPO established appeal procedure as set forth in Section 5 of this Certificate.
- 8.6.7 **Disruptive Behavior.** The PPO may terminate a Member's coverage for cause if the Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his continuing membership in the PPO seriously impairs the PPO's ability to provide Covered Services to either that Member or to other Members. Termination will occur after the PPO has made a reasonable effort to resolve the problem presented by the Member, including encouraging the Member to utilize the PPO's internal appeal procedure as set forth in Section 5 of this Certificate.
- 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, or if coverage terminated under the Certificate because the Member failed to pay required premium

contributions. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA 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.

8.7 Reinstatement.

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

8.7.2 At its 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 thirty-one (31) days of the date of the initial request to terminate that termination is no longer desired.

8.8 Refunds. When a Member's coverage is terminated, any periodic payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded or credited to the Group. Neither the PPO nor Preferred Providers shall have any further liability under this Certificate, except as set forth in Section 8.9.

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

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

whichever comes first.

In the event of coverage terminates because of active employment termination, the Covered Services will be provided during for twelve (12) months during total disability with respect to

the sickness or injury which caused the disability unless coverage is afforded for total disability under another group plan.

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

MISCELLANEOUS.

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

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

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

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

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.

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

8.16 Authorization to Disclose Confidential Information. Subject to the medical records confidentiality provisions below, the PPO is entitled to receive from any provider of Covered

Services to any Member, information reasonably necessary in connection with the administration of this Certificate.

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

8.16.1.1 Cost of Medical Records. The cost of providing medical records to the PPO or a Preferred Provider is a covered benefit if the Covered Services received by the Member are Medically Necessary and provided through a Preferred Provider or upon Precertification by the PPO.

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

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

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

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

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

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

Geisinger Quality Options, Inc.
M.C. 3220
100 North Academy Avenue
Danville, PA 17822
Attention: Administration

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

- 8.23 Substitution of Non-Covered Services.** Other provisions of this Certificate notwithstanding, the PPO reserves the right to provide any service, supply, equipment or benefit which is otherwise **NOT COVERED**, or which is limited or excluded, when, in the sole judgment of the PPO, provision of such service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equivalent benefits available under this Certificate and the Member and his or her attending physician accept such service. Any such substitution shall be subject to such quality assurance standards as the Pennsylvania Department of Health may establish. The Member has the ability to return to the benefits of the Certificate at any time.
- 8.24 Time Limit on Certain Defenses.** No misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void the Certificate or to deny a claim commencing after the expiration of three (3) years from the date of issue of this Certificate.
- 8.25 Legal Actions.** The Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted, if the Member is a member of an ERISA group. No such action shall be brought after the expiration of three (3) years after the time written proof of claims for Covered Services is required to be furnished.
- 8.26 Physical Examination.** The PPO, at its own expense, shall have the right and the opportunity to request a physical examination of the Member upon reasonable notice to determine the validity of a claim.
- 8.27 Certificate of Creditable Coverage.** Upon termination of a Member's coverage, the PPO will automatically issue a Certificate of Creditable Coverage. The Certificate of Creditable Coverage indicates the length of time the Member had continuous health coverage under the PPO. In the event additional Certificates of Creditable Coverage are required, the Member has the right to request them within twenty-four (24) months after coverage terminates or at any time while enrolled in the PPO. A Member may request a Certificate of Creditable Coverage by contacting the Customer Service Team at the telephone number on the Member Identification Card.
- 8.28 Discretionary Authority.** The PPO has the full discretionary authority to make benefit and eligibility determinations and adjudicate claims under the Group's health benefit plan.
- 8.29 Compliance with the Law; Amendment.** Anything contained herein to the contrary notwithstanding, the PPO shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Certificate, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Certificate for any one (1) or more eligible Members enrolled under this PPO, and each party hereby agrees to any amendment of this Certificate which is necessary in

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

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

EXHIBIT 1
GEISINGER CHOICE PPO WITH NO REFERRAL
SERVICE AREA

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

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

BEDFORD COUNTY

- the following zip codes only:

15521
15554
16614
16633
16650
16655
16659
16664
16667
16670
16672
16678
16679
16695

ELK COUNTY

- the following zip codes only:

15821
15822
15823
15827
15831
15841
15846
15860
15868

Exhibit 2
Non-Preferred Provider Cost Sharing Example Chart

As Described in Section 1.9, when using a Non-Preferred Provider, any costs that exceed the PPO’s Non-Preferred Provider Fee Schedule Amount are not included in the Coinsurance Maximum. This means that the Member will be financially responsible for the difference between the PPO’s Non-Preferred Provider Fee Schedule Amount and the Non-Preferred Provider’s billed charge, even if the Coinsurance Maximum has been reached. This could result in significant financial liability for the Member.

The following example illustrates the concept outlined above:

		Member Owes	PPO Pays
Provider’s Charges	\$10,000		
PPO Allowed Amount	\$3,000	\$7,000 (Provider charges, less PPO allowed amount)	
Deductible	\$250	\$250	
Coinsurance (\$2,750 at 10%)	10%	\$275	
PPO Payment (\$3,000 - \$250 - \$275)			\$2,475
Total		\$7,525	\$2,475

NOTE: The figures in this example are for illustration purposes only. Refer to the Schedule of Benefits for the specific Deductible, Coinsurance and/or Copayment amounts which are applicable to this Certificate.