MUELLERS MCDONALDS
Summary Plan Description
Effective
10.1.22

INTRODUCTION

1. The Summary Plan Description.

This Summary Plan Description ("SPD") provides information about the benefits offered under this Welfare Benefit Plan ("Plan") sponsored by MUELLERS MCDONALDS ("Plan Sponsor") for eligible employees. Throughout this Summary Plan Description, you will find information about who is eligible to participate, when coverage begins and ends, what benefits are available and what administrative procedures need to be followed.

This Plan is subject to a contract between MUELLERS MCDONALDS and Geisinger Indemnity Insurance Company ("GIIC"). The role of GIIC is limited to those administrative functions related to the payment and processing of claims and Network access only. GIIC will be referenced in this Summary Plan Description as "Claims Administrator".

The Plan Sponsor intends to continue the Plan indefinitely; however, to the fullest extent allowed by law, the Plan Sponsor reserves the right to change or terminate the Plan at any time for any reason. This document is not a guarantee of benefits or an employment contract of any kind.

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SECTION 1. DEFINITIONS

1. GENERAL DEFINITIONS. The following terms, when used in this Summary Plan Description and all applicable Amendments and Summary 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 Summary Plan Description and is to be attached to and made a part of the Summary Plan Description.

1.4 Benefit Limit means a specific limitation on a benefit which is set forth in the Summary of Summary Plan Description as an age requirement, dollar amount or number of services covered per Benefit Period.

1.5 Benefit Period means the period of time this Summary Plan Description is in effect.

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

1.7 Coinsurance is a form of Cost Sharing (indicated as a percentage amount on the Summary of Benefits) which requires the Member to pay a specified portion of the Participating Provider Fee Schedule Amount or the Non-Participating Provider Fee Schedule Amount after the Deductible has been paid by the Member or Family Unit.

1.8 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 Summary 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 Summary Plan Description and/or Summary of Benefits;
(iv) amounts above the Non-Participating Provider Fee Schedule Amount;
(v) amounts for non-Covered Services; and
(vi) amounts above the Lifetime Benefit Maximum as set forth on the Summary of Benefits.

This means that the Member 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-Participating Providers are utilized.**

Amounts paid toward satisfaction of the Coinsurance Maximum amounts for Covered Services obtained from either Participating or Non-Participating Providers accrue toward satisfaction of both Coinsurance Maximum amounts as set forth on the Summary of Benefits. The Coinsurance Maximum applies to each

Member or Family Unit subject to any family Coinsurance Maximum set forth on the Summary of Benefits.

1.9 **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 Summary 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.

1.10 **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 Summary of Benefits.

1.11 **Covered Service** means a Medically Necessary (unless otherwise indicated) service or supply specified in this Summary Plan Description for which benefits will be provided pursuant to the terms of the Summary Plan Description.

1.12 **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.

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

1.14 **Deductible** means a specified dollar amount for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the Plan Sponsor 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 Summary of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Participating or Non-Participating Providers, as set forth on the Summary of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Participating Providers or Participating Providers accrue toward satisfaction of both Deductible amounts as set forth on the Summary of Benefits. 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.

1.15 **Intentionally Left Blank**

1.16 **Designated Transplant Facility** is a facility that has entered into an agreement with the Claims Administrator, the Claims Administrator's transplant subcontractor or national organ transplant network to provide transplant services when a transplant service as set forth in Section 3.41 is Medically Necessary for a Member. The Designated Transplant Facility is determined by the Claims Administrator or the Claims Administrator's transplant subcontractor and may or may not be located in the Service Area.

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

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

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

b) serious impairment to bodily functions; or

c) serious dysfunction of any bodily organ or part.

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

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

1.20 **Experimental, Investigational or Unproven Services** are any medical, surgical, psychiatric, Substance Abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices (collectively called "technologies") that are determined by the Claims Administrator 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 Claim Administrator 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, III or IV clinical trial set forth in the FDA regulation. Procedure 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 athat would otherwise be covered, and hospital admissions soley 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 Claim Administrator 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.

1.21 **Family Coverage** means the Covered Services provided under this Summary Plan Description for a Subscriber and one or more Family Dependents who are Members under the same Summary Plan Description.

1.22 **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 Summary Plan Description;

b) who is enrolled under this Summary Plan Description;

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 1.36 of this Summary Plan Description.

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

1.24 **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.

1.25 **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.

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

1.26.1 **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.

1.26.2 **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.

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

1.26.4 **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.

1.26.5 **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.

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

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

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

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

1.26.7 **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.

1.26.8 **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.

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

1.27 **Identification Card** means the card issued to a Member pursuant to this Summary Plan Description which is for identification purposes only. Possession of an Identification Card confers no right to Covered Services or other benefits under this Summary Plan Description. 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 Summary Plan Description have actually been paid.

1.28 **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.

1.29 **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.

1.30 **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.

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

1.32 **Maximum Age** means the point in time which a Family Dependent is no longer eligible for coverage as described in Section 6.2.

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

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

a) appropriate for the symptoms and diagnosis and treatment of the Member's condition, illness, disease or injury;

b) provided for the diagnosis, and the direct care and treatment of the Member's condition, illness, disease or injury;

c) in accordance with current standards of good medical treatment practiced by the general medical community;

d) not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

1.35 **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.

1.36 **Member** means an individual eligible to receive Covered Services or benefits under the terms of this Summary Plan Description either as the Subscriber or an individual who is:

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

b) an eligible enrolled Family Dependent, (except as defined under Sections 5, to include a Member's representative and Section 7 for Coordination of Benefit purposes).

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

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

1.39 **Non-Participating Provider Fee Schedule Amount** means the amount of reimbursement that will be provided for Covered Services rendered by a Non-Participating Provider which is generally a percentage of Medicare reimbursement. The Member may obtain the Non-Participating Provider Fee Schedule Amount by contacting the Customer Service Team at the number set forth on the Identification Card.

1.40 **Open Enrollment Period** means those periods of time established by the Plan Sponsor from time to time, during which eligible persons may enroll.

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

1.42 **Participating 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 Claim Administrator to provide Covered Services to Members as a Participating Provider.

1.43 **Participating Provider or Participating Health Care Provider** means a Health Care Provider that has an agreement with the Plan to provide Covered Services to Members under this SPD and pursuant to

which such Health Care Provider is a part of the Plan's Network, except as defined in Section 2.5.2 of this SPD.

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

1.44 **Participating Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the Claim Administrator for Covered Services rendered by a Participating Provider based on the contractual arrangement between the Claim Administrator and the Participating Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Member.

1.45 **Summary Plan Description** refers to this document, which is provided by the Plan to all Subscribers awarded coverage. The Summary Plan Description describes the Covered Services and the terms and conditions of coverage.

1.46 **Primary Care Services** means initial and basic medical health care services provided by a general or family care practitioner, internist or pediatrician.

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

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

1.49 **Provider.** Means a Health Care Provider.

1.50 **Provider List** means a published listing (as amended from time to time) provided to Members which sets forth the names, addresses and telephone numbers of current Participating Providers who have contracted with the Claim Administrator to provide Covered Services. The current Provider List can be found on the Plan's website (atwww.GeisingerHealthPlan.com). A Member may also request a copy of the most current Provider List by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card.

1.51 INTENTIONALLY LEFT BLANK.

1.52 **Service Area** means the Pennsylvania counties listed in EXHIBIT 1, as amended from time to time, for which the Plan is licensed to operate by the Pennsylvania Department of Health.

1.53 **Specialist** means a Participating 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.

1.54 **Subscriber** means an individual who meets the requirements for eligibility, who has enrolled in the Plan, and for whom payment has actually been received by the Plan Sponsor. A Subscriber is also a Member.

1.55 **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.

1.56 **Summary of Benefits** is a summary of coverage for a Member that identifies the applicable Deductible, Copayments, Coinsurance, Coinsurance Maximums, Benefit Limits and Lifetime Benefit Maximum amounts for Covered Services in force with the Plan.

1.57 **Summary Plan Document ("SPD")** refers to this document, which is provided by the Plan to all Subscribers awarded coverage. The SPD describes the Covered Services and the terms and conditions of coverage.

1.58 **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 Claim Administrator's website at www.thehealthplan.com. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.

1.59 **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.

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

(i) amounts above a specific Benefit Limit as set forth in the Summary Plan Description and/or Summary of Benefits; and
(ii) amounts for non-Covered Services.

This means that the Member will be responsible for payment of all these amounts noted above, even if the Maximum Out-of-Pocket has been reached. Amounts paid toward satisfaction of the Maximum Out-of-Pocket amounts for either PCP referred Covered Services or Self-Referred Services do not accrue towards each other. The Maximum Out-of-Pocket applies to each Member or Family Unit subject to any family Maximum Out-of-Pocket set forth on the Summary of Benefits.

1.61 **Telahealth** means remote clinical services and remote non-clinical services.

SECTION 2. PHYSICIAN-PATIENT RELATIONSHIP AND MEDICAL MANAGEMENT PROCEDURES

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

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

a) an independent contractor;

b) the employee of an independent contractor; or

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

Primary Care Physicians and all other Participating Provider physicians are not servants, employees or agents, actual or apparent, of the Claim Administrator or the Plan Sponsor.

2.3 Choice of Primary Care Physician. Upon enrollment, the Subscriber shall choose a Primary Care Physician for himself and for each enrolled Family Dependent. The Provider List indicates the Primary Care Physicians who are part of the Plan's Network. Any child Family Dependent shall be entitled to have a pediatrician as his/her Primary Care Physician. The Provider List indicates the Primary Care Physicians and pediatricians who are part of the Plan's Network.

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

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

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

2.4 Primary Care and Covered Services. A Member may obtain primary care service and other Covered Services under the terms of this Summary Plan Description. All Covered Services must be received from either the Member's Primary Care Physician or another Participating Provider, except Emergency Services.

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

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

2.5 Continuity of Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) verbally;

b) through an Advance Health Care Directive; or

c) through a properly appointed surrogate.

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

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

2.8 Medical Management Procedures. The following is a description of the Plan's Medical Management Procedures.

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

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

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

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

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

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

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

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

SECTION 3. COVERED SERVICES

Subject to the exclusions, conditions and limitations of this Summary Plan Description, 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 Summary of Benefits and in accordance with the procedures set forth in Section 2 of this Summary Plan Description. The fact that a Provider prescribed, ordered, recommended or approved a medical service or supply does not automatically constitute coverage under this Plan.

Please be advised that the benefits set forth in this Summary Plan Description are subject to the Copayments, Coinsurance, Deductibles, Coinsurance Maximums, Benefit Limits and Lifetime Benefit Maximums that are specifically set forth on the Summary of Benefits as well as the individual Benefit Limits set forth in this Summary Plan Description and on the Summary of Benefits.

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

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

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

3.1.1 **Covered Services from a Participating Provider**. A Member may access Covered Services from a Participating Provider.

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

a) Emergency Services as set forth in Section 3.7 of this Summary Plan Description;

b) Urgent Care as set forth in detail in Section 3.43 of this Summary Plan Description;

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

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

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

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

3.1.3.2 **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 not covered.

3.1.3.3 **Maternity care outside the Service Area**. Maternity care for normal term delivery if received outside the Service Area will not be covered at the Participating Provider rate if rendered by a Non-Participating Provider. Treatment of unexpected complications of pregnancy and care for unexpected early delivery are covered as Emergency Services.

3.1.4 **Covered Service Location Cost Sharing**. Certain Covered Services will subject the Member to a Cost Sharing obligation based on the type of facility where the Covered Service is provided (examples include, but are not limited to, dental anesthesia and hospice services). This location Cost Sharing is in addition to any Cost Sharing obligation for the Covered Service being provided to the Member.

3.1.5 **Second Opinion Coverage**: A second opinion relating to a Covered Service is covered when received from a Participating Provider or from a Non-Participating Provider when the Member obtains Prior Authorization.

IDENTIFICATION OF COVERED SERVICES

Subject to all terms, conditions, definitions, exclusions and limitations in this Summary Plan Description, 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 3.30 and **EXHIBIT 2** of this Summary Plan Description.

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 Participating Provider. The Plan reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.

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

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

3.3.3 **Prescription Drugs.** The Plan will cover insulin and oral pharmacological agents for controlling blood sugar as prescribed by a Participating Provider 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 Summary of Benefits.

3.3.4 **Outpatient Training and Education.** Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered under the supervision of a Participating Provider with expertise in diabetes to ensure that Members with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. This shall include visits:

i) upon the diagnosis of diabetes;

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

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

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

3.3.5 **Diabetic Eye Examniations.** Diabetic eye examinations are covered when provided by a Participating Provider. A diabetic eye examination does not include a refraction of the eye (s).

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

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

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 4.63 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 Plan.

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

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

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

Rehabilitative Devices do not include:

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

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

3.6.2 **Durable Medical Equipment (DME) and Related Supplies.** Upon Prior Authorization, the Plan will cover the cost of renting, or at its option, purchasing Medically Necessary DME and Related Supplies when prescribed in advance by a Participating Provider for use consistent with required Food and Drug Administration (FDA) approved labeling for the item. This benefit includes the cost of delivery and installation. Repair and replacement of DME is covered only to the extent required as a result of normal wear and tear. DME must be obtained from a Participating Provider. The Claim Administrator reserves the right to recover any DME purchased under the Plan when such device or piece of equipment is no longer Medically Necessary or in the event that the Member is not Compliant in utilization of the equipment as indicated in the course of treatment and determined by the Claim Administrator. Coverage of DME is subject to the Exclusions set forth in Section 4.63 of this Summary Plan Description.

3.6.2.1 **Durable Medical Equipment Vendors**. The Claim Administrator reserves the right to restrict the selection of vendors for DME covered under this Summary Plan Description.

3.6.2.2 **Manufacturer.** The Claim Administrator reserves the right to restrict the manufacturer of Durable Medical Equipment covered under this Summary Plan Description. Such restriction is subject to change without the consent or concurrence of the Member except as provided for herein.

3.6.3 **Orthotic Devices**. The Plan will pay for the purchase of Orthotic Devices when prescribed in advance by a Participating Provider or when approved in advance by the Claim Administrator. Standard Orthotic Devices must be obtained from a Participating Provider unless authorized in advance by theClaim Administrator. Coverage of Orthotic Devices is subject to the Exclusions set forth in Section 4.63 of this Summary Plan Description.

3.6.4 **Prosthetic Devices**. The Plan will pay for the purchase of one (1) Prosthetic Device or the replacement of component parts or modification of an existing Prosthetic Device every five (5) years when obtained from a Participating Provider subject to the Exclusions set forth in Section 4.63 of this SPD. However, the following Covered Services are not subject to the five (5) year Benefit Limit set forth above.

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

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

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 Prosthetic Device occasioned by the Member’s growth, in addition to the initial purchase of such a device.

3.6.4.2 **Manufacturer**. The Claim Administrator reserves the right to restrict the manufacturer of Prosthetic Devices covered under this Summary Plan Description. Such restriction is subject to change 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 Summary of Benefits.

3.7 Emergency Services. Emergency Services do not require Precertification. 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 Participating Provider, the Plan shall cover the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Participating Provider, subject to Sections 3.7.1(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 Claim Administrator within forty-eight (48) hours, or on the next business day, whichever is later, of the Emergency Services rendered to the Member.

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

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

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

f) For the emergency treatment of sound, natural teeth please refer to Section 3.26.2, Oral Surgery**.** The need for these services must result from an accidental injury (not chewing or biting).

3.7.2 **Non-Participating Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Participating Provider, the Plan shall pay for the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Participating Provider. However, Emergency Services provided by Non-Participating Providers will be covered as if provided by a Participating Provider only until the Plan determines the Member's condition has stabilized and the Member can be transported to a Participating Provider without suffering detrimental consequences or aggravating the Member's condition. Such transportation is not subject to the Copayment amount (as set forth on the Summary of Benefits) normally applied to transportation services.

3.7.3 **Cost Sharing.** Emergency Services are subject to the emergency room Cost Sharing specified on the Summary of Benefits. The Cost Sharing will be waived if Emergency Services rendered in

the emergency department of an acute care hospital result in the immediate admission of the Member to the hospital as an inpatient and the requirements for Emergency Services are satisfied.

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

3.8 INTENTIONALLY LEFT BLANK

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 4.18 of this Summary Plan Description.

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

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

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

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

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

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

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

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

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

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

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

3.12 Hepatitis C – Center of Excellence

3.12.1 **Definition.** For purposes of this Section 3.12, Center of Excellence ("COE") shall mean a Participating Health Care Provider designated by the Plan. Member should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

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

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

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

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

3.13 Home Health Care. Home health care is covered only in the event a Member is homebound except as provided in Section 3.13.4 of this Summary Plan Description. 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 3.21 of this Summary Plan Description.

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

3.13.1 **Skilled Nursing Personnel.** Skilled nursing visits in the home that are provided by skilled nursing personnel who are Participating Providers, and who are supervised by physician Providers, are covered when ordered by the Member's Primary Care Physian or Participating Provider.

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

3.13.3 **Other Health Care Personnel.** Medical care in the home is covered when the care is given by Health Care Participating Providers (including but not limited to, speech, physical and occupational therapists) under the supervision of a physician Participating Provider. Home health care services are also subject to any specific benefit limitations set forth in this Section 3 of the Summary Plan Description.

3.13.4 **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.

3.14 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 Summary Plan Description, provided such care is:

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

b) directly related to the Terminal Illness of a Member andrendered in accordance with the Member's Plan of Care and through a Participating Provider.

3.14.1 **Hospice Benefit Election.** The Member shall have the option to elect to receive Hospice benefits as set forth in this Summary Plan Description. 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 Plan's standard benefits for treatment of the Terminal Illness and related conditions; and

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

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

3.15 Hospital and Ambulatory Surgical Center Services.

3.15.1 **Benefits.** Hospital benefits may be provided at a hospital Participating Provider on either an inpatient or outpatient basis or at an Ambulatory Surgical Center. Hospital services include semi-private room and board (private room when determined Medically Necessary by the Claim Administrator), general nursing care and the following additional facilities, services and supplies as prescribed by a Participating Provider (or another physician in response to an emergency): use of operating room and related facilities; use of intensive care unit or cardiac care unit and services; radiology, laboratory, and other diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; physical therapy, occupational therapy and speech therapy (subject to the Benefit Limits set forth in Section 3.32 of this Summary Plan Description and on the Summary 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.

3.15.2 **Prior Authorization.** All non-emergency inpatient hospital admissions require Prior Authorization.

3.15.3 **Duration of the Benefit.** Except for mastectomy Covered Services as set forth in Section 3.20, inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the Claim Administrator and not determined to be Custodial, Convalescent or Domiciliary Care.

3.16 Impacted Wisdom Teeth. Subject to Section 3.16.1 below, Cost Sharing set forth on the Summary of Benefits and applicable Exclusions set forth in Section 4, the Plan will cover consultation and services related to the extraction of partially or totally bony impacted third molars when performed by a Participating Provider.

3.16.1 Hospital and Ambulatory Surgical Center services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, are covered if the hospital services are required for an existing medical condition unrelated to the dental or oralsurgical procedure or as set forth in SPD Section 3.11, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care. Such coverage must be authorized in advance by the Plan.

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

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

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

3.19 Injectable Drugs. Injectable drugs are covered and subject to the Cost Sharing set forth in the Summary of Benefits. Select injectable drugs are covered as set forth separately in Section 3.35.

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

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

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

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

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

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

3.21 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the Provider. Certified licensed nurse midwife Participating Provider services shall be covered only if obtained from a Participating Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.24 of this Summary Plan Description.

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

3.21.2 **Childbirth Preparedness Classes.** Childbirth preparedness classes for education focused on preparing for labor and the birth of a child are covered for pregnant female Members up to a $100 limit per Benefit Period. Such classes may not be related solely to child rearing. In order to be reimbursed by the Plan for a childbirth preparedness class, the Member must follow the requirements of Section 9.4 of the Summary Plan Description. However, the Member is **not required** to follow the claim form requirements set forth in Section 9.4.1 of the Summary Plan Description; instead, the Member should submit a copy of the Childbirth preparedness class receipt indicating the payment amount and the completion date of the class.

3.22 Medical Foods

(a) Enteral Feeding/Food Supplements. The cost of outpatient enteral tube feedings including administration, supplies and formula used as food supplements is covered for nutritional supplements for the therapeutic treatment of aminoacidopathic hereditary metabolic disorders (phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria) when administered under the direction of a physician Participating Provider. Upon Prior Authorization, coverage consideration may also be given when enteral or parenteral feeding is the sole source of nutrition.

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

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

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

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

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

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

Mental Illness Inpatient Facility Services and Inpatient Professional Services" Cost Sharing as set forth on the Summary of Benefits.

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

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

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

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

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

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

3.24 Newborn Coverage. Newborn children are covered as a Member from birth for the first thirty-one (31) days of life. Such coverage shall include any Medically Necessary hospital and physician services required by a newborn child of a Member when ordered or provided by Participating Providers for the treatment of medically diagnosed congenital defects and birth abnormalities (as also set forth in Section 3.34.1 of this Summary Plan Description); prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Section 6.2.1.2 or 8.2 of this Summary Plan Description (if applicable).

3.25 Occupational Therapy Services. See Section 3.32, Physical and Occupational Therapy Services.

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

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

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

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

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

3.26.4 **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 Prior Authorization.

3.26.5 **General Anesthesia and Associated Medical Costs** provided in connection with an inpatient or outpatient oral surgery procedure are covered as set forth in Section 3.11 of this Summary Plan Description.

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

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

3.28 INTENTIONALLY LEFT BLANK.

3.29 Physician Services.

3.29.1 **Hospital and Ambulatory Surgical Center Physician Services.** The services listed in Section 3.15.1 are covered physician services in a hospital or Ambulatory Surgical Center under the following conditions:

a) **Hospital.** The services set forth in Section 3.15.1 of this Summary Plan Description are Covered Services when provided by physician Participating 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 3.15.1 of this Summary Plan Description are Covered Services when provided in an Ambulatory Surgical Center setting by physician Participating Providers (or other physicians in response to an emergency) or under the orders of a physician.

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

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

b) inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in an acute hospital.

3.29.3 **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 3.30 below under **Preventive Services** in this Summary Plan Description when obtained from a Participating Provider as set forth in Section 3.1.1.;

b) cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer by a Participating Provider;

c) injectable drugs (including those injectable drugs listed in Section 3.35 of this Summary Plan Description) 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;

d) diagnostic and treatment Covered Services provided by a Specialist;

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

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

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

a) physical examination;

3.30.1.1 **Periodic Health Assessment Cost Sharing.** For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.30.1, above, refer to the Summary of Benefits. The Cost Sharing associated with these Covered Services will differ depending upon whether the services were provided by a Primary Care Physician or a Specialist.

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

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

3.32 Rehabilitative Services. Physical and occupational therapy, on either an outpatient or inpatient basis is covered; however, Prior Authorization is required for: (i) outpatient/inpatient rehabilitative facility services provided by Non-Participating and (ii) inpatient services provided in a rehabilitation facility.

3.32.1 **Physical Therapy for Back/Neck-Related Pain.** Upon Prior Authorization, physical therapy for back/neck related pain is covered. Cost Sharing applicable to the first ten (10) physical therapy

visits for back/neck related pain will be bundled into two (2) series of five (5) visits per series. Cost Sharing applicable to each visit subsequent to the tenth (10^{th}) visit is also noted on the Summary of Benefits.

3.32.2 **Speech Therapy Services.** Upon Prior Authorization, speech therapy, on either an outpatient or inpatient basis is covered.

3.33 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period when the service is obtained from a Participating Provider.

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

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

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

3.35 Select Injectable Drugs. Subject to the terms and conditions set forth in this Summary Plan Description, the following injectable drugs are a Covered Service.

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

- Azedra (iobenguane I 131)
- Bavencio (avelumab)
- Baxdela IV (delafloxacin meglumine)
- Bebulin (Antihemophilic Factor IX Complex, Human)
- Beleodaq (belinostat)
- Bendeka (bendamustine hydrochloride)
- Benefix (Antihemophilic Factor IX, Recombinant)
- Benlysta (belimumab)
- Beovu (brolucizumab-dbll)
- Berinert (C1 esterase inhibitor, human)
- Besponsa (inotuzumab ozogamicin)
- Bivigam (immune globulin intravenous)
- Blenrep (belantamab mafodotin)
- Blincyto (blinatumomab)
- Botox (botulinum toxin type A)
- Breyanzi (lisocabtagene maraleucel)
- Brineura (cerliponase alfa)
- Cabenuva (cabotegravir and rilpivirine)
- Cablivi (caplacizumab-yhdp)
- Carimune (intravenous immune globulin)
- Cerezyme (imiglucerase)
- Cimzia IV (certolizumab pegol)
- Cinqair (reslizumab)
- Cinryze (C1 esterase inhibitor, human)
- Cinvanti (aprepitant)
- Clolar (clofarabine)
- Coagadex (Factor X (Human))
- Corifact (factor XIII concentrate)
- Cosela (trilaciclib)
- Cresemba (isavuconazonium sulfate)
- Crysvita (burosumab-twza)
- Cubicin/Cubicin RF (daptomycin)*
- Cutaquig (immune globulin subcutaneous, human -hipp)
- Cuvitru (subcutaneous immune globulin)
- Cyramza (ramucirumab)
- Dacogen (decitabine)*
- Dalvance (dalbavancin)
- Danyelza (naxitamab)
- Daptomycin
- Darzalex (daratumumab)
- Darzalex Faspro (daratumumab/hyaluronidase)
- Decitabine
- Dextenza (dexamethasone ophthalmic)
- Dexycu (dexamethasone ophthalmic)
- Duopa (carbidopa/levodopa
- Durolane (sodium hyaluronate)
- Durysta (bimatoprost)
- Dysport (botulinum toxin Type A)
- Elaprase (idursulfase)
- Elelyso (taliglucerase alfa)
- Eligard (leuprolide)
- Elitek (rasburicase)

- Eloctate (Antihemophilic Factor VIII, Recombinant, FC)
- Eloxatin (oxaliplatin)*
- Elzonris (tagraxofusp-erzs)
- Empliciti (elotuzumab)
- Enhertu (fam-trastuzumab deruxtecan-nxki)
- Entyvio (vedolizumab)
- Epogen (epoetin alfa, recombinant)
- Epoprostenol Sodium
- Erbitux (cetuximab)
- Erwinaze (asparaginase)
- Esperoct (antihemophilic factor, (recombinant) glycopegylated-exei)
- Esperoct (turoctocog alfa pegol)
- Euflexxa (hyaluronate sodium)
- Evenity (romosozumab-aqqg)
- Evkeeza (evinacumab)
- Exondys 51 (eteplirsen)
- Eylea (aflibercept)
- Fabrazyme (agalsidase beta)
- Fasenra (benralizumab)
- Faslodex (fulvestrant)
- Feiba NF (Anti-inhibitor Coagulant Complex)
- Fensolvi (leuprolide)
- Feraheme (ferumoxytol)
- Fetroja (cefiderocol sulfate tosylate)
- Firmagon (degarelix)
- Flebogamma (intravenous immune globulin)
- Flolan (epoprostenol)*
- Folotyn (pralatrexate)
- Fulphila (pegfilgrastim-jmdb)
- Gamifant (emapalumab-lzsg)
- Gammagard (subcutaneous/intravenous immune globulin)
- Gammaked (subcutaneous/intravenous immune globulin)
- Gammaplex (intravenous immune globulin)
- Gamunex-C (subcutaneous/intravenous immune globulin)
- Gazyva (obinutuzumab)
- Gel-One (cross-linked hyaluronate)
- Gelsyn-3 (sodium hyaluronate)
- Gen Visc 850 (sodium hyaluronate)
- Givlaari (givosiran)
- Glassia (alpha1-proteinase inhibitor, human)
- Granix (tbo-filgrastim)
- Halaven-T (erubulin)
- Helixate FS (Antihemophilic Factor VIII, Recombinant)
- Hemlibra (emicizumab-kxwh)
- Hemofil M (Antihemophilic Factor VIII, Human)
- Herceptin (trastuzumab)
- Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)
- Herzuma (trastuzumab-pkrb)
- Hizentra (subcutaneous immune globulin)
- Humate-P (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- Hyalgan (hyaluronate sodium)
- hydroxyprogesterone caproate

- Hymovis (hyaluronan)
- Hyqvia (subcutaneous immune globulin/hyaluronidase)
- Idelvion (antihemophilic factor IX (recombinant))
- Ilaris (canakinumab)
- Ilumya (tildrakizumab-asmn)
- Iluvien (fluocinolone acetonide [ophthalmic implant])
- Imfinzi (durvalumab)
- Imlygic (talimogene laherparepvec)
- Inflectra (infliximab-dyyb)
- Injectafer (ferric carboxymaltose)
- Invega Sustenna (paliperidone palmitate)
- Invega Trinza (paliperidone palmitate)
- Istodax (romidepsin)
- IVIG (intravenous immune globulin)
- Ixempra (ixabepilone)
- Jelmyto (mitoMYcin)
- Jevtana (cabazitaxel)
- Jivi (antihemophilic factor (recombinant), PEGylated-aucl)
- Kadcyla (ado-trastuzumab emtansine)
- Kalbitor (ecallantide)
- Kanjinti (trastuzumab-anns)
- Kanuma (sebelipase alfa)
- Kcentra (prothrombin complex concentrate)
- Kepivance (palifermin)
- Keytruda (pembrolizumab)
- Khapzory (levoleucovorin)
- Koate-DVI (Antihemophilic Factor VIII, Human)
- Kogenate FS (Antihemophilic Factor VIII, Recombinant)
- Kovaltry (antihemophilis factor)
- Krystexxa (pegloticase)
- Kymriah (tisagenlecleucel)
- Kyprolis (carfilzomib)
- Lemtrada (alemtuzumab)
- Leukine (sargramostim)
- Libtayo (cemiplimab-rwlc)
- Lucentis (ranibizumab)
- Lumizyme (alglucosidase alfa)
- Lumoxiti (moxetumomab pasudotox-tdfk)
- Lupaneta (leuprolide acetate/norethindrone acetate)
- Lupron Depot (leuprolide acetate)
- Lutathera (lutetium lu 177 dotatate)
- Luxturna (voretigene neparvovec-rzyl)
- Macugen (pegaptanib)
- Makena (hydroxyprogesterone caproate injection)
- Margenza (margetuximab)
- Marqibo (vincristine sulfate liposome injection)
- Mepsevii (vestronidase Alfa-vjbk)
- Mircera (methoxy polyethylene glycol-epoetin beta)
- Mitosol (mitomycin)
- Monjuvi (tafasitamab)
- Monoclate-P (Antihemophilic Factor VIII, Human)
- Mononine (Antihemophilic Factor IX, Human)

- Monovisc (hyaluronan)
- Mozobil (plerixafor)
- Mvasi (bevacizumab-awwb)
- Mylotarg (gemtuzumab ozogamicin)
- Myobloc (rimabotulinumtoxin B)
- Naglazyme (galsulfase)
- Neulasta (pegfilgrastim)
- Neupogen (filgrastim)
- Nivepria (pegfilgrastim)
- Nivestym (filgrastim-aafi)
- Novoseven RT (Coagulation Factor VIIa, Recombinant)
- N-Plate (romiplostim)
- Nucala (mepolizumab)
- Nulibry (fosdenopterin)
- Nulojix (belatacept)
- Nuwiq (Antihemophilic Factor VIII, Recombinant)
- Nuzyra IV (omadacycline tosylate)
- Obizur (Antihemophilic Factor VIII, Recombinant, Porcine Sequence)
- Ocrevus (ocrelizumab)
- Octagam (intravenous immune globulin)
- Ogivri (trastuzumab-dkst)
- Olinvyk (oliceridine)
- Oncaspar (pegaspargase)
- Onivyde (irinotecan (liposomal))
- Onpattro (patisiran)
- Ontruzant (trastuzumab)
- Opdivo (nivolumab)
- Orbactiv (ortivancin)
- Orencia IV (abatacept)
- Orthovisc (hyaluronate sodium)
- Oxaliplatin
- Oxlumo (lumasiran)
- Ozurdex (dexamethasone [opthalmic implant])
- Padcev (enfortumab vedotin-ejfv)
- Panzyga (immune globulin intravenous, human - ifas)
- Parsabiv (etelcalcetide)
- Pepaxto (melphalan flufenamide)
- Perjeta (pertuzumab)
- Perseris (risperidone)
- Phesgo (pertuzumab, trastuzumab, and hyaluronidase)
- Polivy (polatuzumab vedotin-piiq)
- Portrazza (necitumumab)
- Poteligeo (mogamulizumab-kpkc)
- Praxbind (idarucizumab)
- Prevymis (letermovir)
- Prialt (ziconotide)
- Privigen (intravenous immune globulin)
- Probuphine (buprenorphine)
- Procrit (epoetin alfa, recombinant)
- Profilnine SD (Antihemophilic Factor IX Complex, Human)
- Prolastin (alpha1-proteinase inhibitor, human)
- Prolia (denosumab)

- Provenge (sipuleucel-T)
- Radicava (edaravone)
- Rapivab (peramivir)
- Rebinyn (coagulation factor IX (recombinant), glycopegylated)
- Reblozyl (luspatercept-aamt)
- Recarbrio (imipenem/cilastatin sodium/relebactam)
- Recombinate (Antihemophilic Factor VIII, Recombinant)
- Remicade (infliximab)
- Remodulin (treprostinil)
- Renflexis (infliximab-abda)
- Retacrit (epoetin alfa-epbx)
- Retisert (fluocinolone acetonide [ophthalmic implant])
- Revcovi (elapegademase-lvlr)
- Risperdal Consta (risperidone microspheres)
- Rituxan (rituximab)
- Rituxan Hycela (rituximab/hyaluronidase)
- Rixubis (coagulation factor IX)
- Ruconest (C1 esterase inhibitor [recombinant])
- Ruxience (rituximab-pvvr)
- Sandostatin LAR (octreotide)
- Sarclisa (isatuximab-irfc)
- Scenesse (afamelanotide)
- Signifor LAR (pasireotide)
- Simponi Aria (golimumab)
- Sivextro (tedizolid)
- Soliris (eculizumab)
- Somatuline Depot (lanreotide)
- Spinraza (nusinersen)
- Spravato (esketamine)
- Stelara (ustekinumab)
- Sublocade (buprenorphine)
- Supartz/Supartz FX (hyaluronate sodium)
- Supprellin LA (histrelin acetate)
- Surfaxin (lucinactant)
- Sustol (granisetron)
- Sylvant (siltuximab)
- Synagis (palivizumab)
- Synribo (omacetaxine mepesuccinate)
- Synvisc (hylan G-F 20)
- Synvisc-One (hylan G-F 20)
- Tecartus (brexucabtagene autoleucel)
- Tecentriq (atezolizumab)
- Teflaro (ceftaroline fosamil)
- Tepadina (thiotepa)
- Tepezza (teprotumumab-trbw)
- Thrombate III (Antithrombin III, Human)
- Thyrogen (thyrotropin alfa)
- Torisel (temsirolimus)
- Trazimera (trastuzumab-qyyp)
- Treanda (bendamustine)
- Trelstar (triptorelin)
- Tretten (Factor XIII A-Subunit)

- Triluron (hyaluronate and derivatives)
- Triptodur (triptorelin pamoate)
- Trisenox (arsenic trioxide)
- Trivisc (sodium hyaluronate)
- Trodelvy (sacituzumab govitecan)
- Trogarzo (ibalizumab-uiyk)
- Truxima (rituximab-abbs)
- Tysabri (natalizumab)
- Udenyca (pegfilgrastim-cbqv)
- Ultomiris (ravulizumab-cwvz)
- Unituxin (dinutuximab)
- Uplizna (inebilizumab)
- Vabomere (meropenem/vaborbactam)
- Vectibix (panitumumab)
- Velcade (bortezomib)
- Veletri (epoprostenol)*
- Viltepso (viltolarsen)
- Vimizim (elosulfase alfa)
- Visco-3 (sodium hyaluronate)
- Vistide (cidofovir)
- Visudyne (verteporfin)
- Vivitrol (naloxone injection)
- Vonvendi (von willebrand factor)
- Voraxaze (glucarpidase)
- VPRIV (velaglucerase alfa)
- Vyepti (eptinezumab-jjmr)
- Vyondys 53 (golodirsen)
- Vyxeos (daunorubicin/cytarabine (liposomal))
- Wilate (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- Xembify (immune globulin subcutaneous, human -klhw)
- Xembify (immune globulin)
- Xenleta (lefamulin)
- Xeomin (incobotulinumtoxina)
- Xerava (eravacycline)
- Xgeva (denosumab)
- Xiaflex (collagenase clostridium histolyticum)
- Xofigo (radium RA 223 dichloride)
- Xolair (omalizumab)
- Xyntha (Antihemophilic Factor VIII, Recombinant, PAF)
- Yervoy (ipilimumab)
- Yescarta (axicabtagene ciloleucel)
- Yondelis (trabectedin)
- Yutiq (fluocinolone acetonide)
- Zaltrap (ziv-aflibercept)
- Zarxio (filgrastim-sndz)
- Zemaira (alpha1-proteinase inhibitor, human)
- Zemdri (plazomicin sulfate)
- Zepzelca (lurbinectedin)
- Zerbaxa (ceftolozane/tazobactam)
- Zevalin (ibritumomab tiuxetan)
- Ziextenzo (pegfilgrastim-bmez)
- Zilretta (triamcinolone acetonide)

- Zinplava (bezlotoxumab)
- Zirabev (bevacizumab-bvzr)
- Zolgensma (Onasemnogene Abeparvovec)
- Zulresso (brexanolone)
- Zyprexa Relprevv (olanzapine)

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

3.35.1 Cost Sharing.

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

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

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

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

3.37 INTENTIONALLY LEFT BLANK.

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

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

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

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

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

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

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

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

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

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

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

3.40 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 Claim Administrator. The surgical coverage requires Prior Authorization and must be provided in a facility Participating Provider that is designated as an approved Level 1 Bariatric Center of Excellence.

3.41 Transplant Services and Authorization Requirements.

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

(i) bone marrow (allogeneic and autologous);
(ii) cornea (does not require 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 Summary Plan Description may also receive coverage by the Plan's Designated Transplant Facility for certain services that would not otherwise be provided for under this Summary Plan Description.

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

3.41.3 **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.

3.41.4 **Additional Opinion Policy for Transplants.** If a Member receives written notification from the Plan indicating the Member is ineligible for a transplant procedure by a Designated Transplant Facility, the Member may request a second opinion by another Designated Transplant Facility. The Member must contact the Claim Administrator 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 Claim Administrator to obtain adequate information to make a determination regarding the proposed transplant procedure.

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

a) when the organ transplantation is approved by the Plan;

b) for the medical expense directly associated with the organ donation; and

c) to the extent not covered by any other program of insurance.

3.41.5.1 **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.

3.41.7 **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 the Outpatient Prescription Drug benefit.

3.41.7.1 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 Outpatient Prescription Drug coverage;

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

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

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

Covered Services provided under this Section are subject to the applicable Cost Sharing specified on the Summary of Benefits.

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

3.41.9 **Retransplantation Services.** Retransplantation surgery and retransplantation-related services require Prior Authorization.

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

3.42.1 **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 Summary Plan Description.

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

3.43 Urgent Care. Urgent Care services received through Participating Providers in the Service Area are covered. Urgent Care services obtained from a Non-Participating Provider outside of the Service Area are covered at the Participating 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.

3.43.1 **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.

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

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

a) professional services provided by a Member's Primary Care Physician or obstetrical or gynecological Participating Health Care Provider related to the prescribing, fitting and/or insertion of a contraceptive device covered by this Summary Plan Description; and

b) services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Summary Plan Description in Sections 4.14 and 4.26).

3.46 Weight Management Program. The Plan offers a program for weight management that includes education and management for appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. Weight management program services are covered when provided by the Plan'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 Plan's designated weight management program vendors.

3.47 Amyloidosis – Center of Excellence

3.47.1 **Definition.** For purposes of this Section 3.47, Center of Excellence ("COE") shall mean a Participating Health Care Provider designated by the Plan. Members should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

3.47.2 **Amyloidosis.** Covered Services for the treatment of amyloidosis include evaluation by a multidisciplinary team, including but not limited to a board-certified specialist, nurse educator, clinical pharmacist, and/or a case management professional. Additionally, when recommended by a Participating Provider at the COE, and upon prior authorization, medication for the treatment of amyloidosis is covered.

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

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

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

SECTION 4. EXCLUSIONS

4. EXCLUSIONS. THE FOLLOWING ARE NOT COVERED under this Summary Plan Description:

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

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

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

4.4 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 the following Supplemental Health Services: Autism Spectrum Disorder Services.

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

4.6 Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.20 of this Summary Plan Description.

4.7 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.

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

4.9 Cosmetic Surgery. Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the Claim Administrator, is **NOT COVERED**. This exclusion does not apply to Covered Services set forth in Sections 3.20, 3.34.1 or 3.34.2 of this Summary Plan Description.

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

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

4.12 **Dentistry.** This Plan does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the Plan will cover expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.26.2 of this Summary Plan Description (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 Impacted Wisdom Teeth benefit and General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care as set forth in Section 3.11.

4.13 **Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Summary Plan Description in Sections 3.3.3 and 3.41.7 or as set forth in **EXHIBIT 2, Preventive Services,** or as may be explicitly provided under the terms of the [Outpatient Prescription Drug supplemental health service] and Autism Spectrum Disorder Services supplemental health service.

4.14 **Drugs and Devices for Purposes of Contraception.** Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of the Outpatient Prescription Drug Supplemental Health Service with Contraceptive coverage and **EXHIBIT 2**, **Preventive Services**.

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

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

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

4.18 **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**.

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

4.21 **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**.

4.22 **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 Plan is the secondary carrier.

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

4.24 **Hypnosis.** Hypnosis is **NOT COVERED**.

4.25 **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**.

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

4.27 **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 Summary Plan Description, are **NOT COVERED.**

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

4.29 **Manipulative Treatment Services.** Manipulative treatment services are services rendered for the treatment or diagnosis of neuromusculoskeletal disorders and are **NOT COVERED.**

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

4.31 **[Intentionally Left Bank]**

4.32 **[Intentionally Left Bank]**

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

4.34 **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.**

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

4.36 **Not Medically Necessary.** Covered Services which are not considered Medically Necessary by the Claim Administrator are **NOT COVERED** unless set forth as a Covered Service under Section 3.30 or **EXHIBIT 2**, **Preventive Services**.

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

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

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

4.40 **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.

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

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 Summary Plan Description, 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 3.27 of this Summary Plan Description.

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

4.46 **Refraction Examinations.** Examinations to determine the refractive erros of the eye are **NOT COVERED**.

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

(i) Optical materials (eyeglasses, contact lenses) or their fitting, repair or replacement.

(ii) Additional ophthalmological services provided during the same visit as the refractive exam, unless such services provided for in the SPD.

(iii) Refraction services that are not obtained from Participating Providers.

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

4.49 **Reversal of Genital Surgery**. Surgical procedures to reverse genital surgery are **NOT COVERED**, except as stipulated in Section 4.55, **Services Provided in Conjunction with a Non-Covered Service**.

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

4.51 **Reversal of Surgery to Revise Secondary Sex Characteristics**. Surgical procedures to reverse secondary sex characteristic surgery are **NOT COVERED**, except as stipulated in Sectoin 4.65, **Services Provided in Conjunction with a Non-Covered Service**.

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

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

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

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

4.56 Services Provided in Conjunction with a Non-Covered Service. Any service, which would otherwise be a Covered Service under this Summary Plan Description, when provided in conjunction with the provision of a non-Covered Service, is **NOT COVERED**. Such services may include but are not limited to anesthesia or diagnostic services. This exclusion does not include Medically Necessary Covered Services incurred due to complications resulting from a Member's receipt of a non-Covered Service or General Anesthesia and Associated Medical Costs as set forth in Section 3.11.

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

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

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

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

a) provided by the Member's Primary Care Physician;

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

c) authorized in advance by the Designated Behavioral Health Benefit Program;

d) performed by a Participating Provider; or

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

Emergency Services provided inside or outside the Service Area do not require authorization. See Section 3.7 of this Summary Plan Description for the Emergency Services protocol.

4.62 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.

4.63 Weight Control. Weight management programs for non-morbid obesity are **NOT COVERED** unless as provided for in Section 3.46 of this Summary Plan Description or as set forth in **EXHIBIT 2, Preventive Services.**

4.64 THE FOLLOWING DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC DEVICES AND PROSTHETIC DEVICES ARE NOT COVERED:

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

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

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

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

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

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

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

4.64.8 **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.**

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

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

4.64.11 **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**.

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

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

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

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

4.64.16 **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.**

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

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

4.64.19 **Repair or Replacement** of any piece of equipment/device, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in Section 3.6.2 of this Summary Plan Description.

4.64.20 **Replacement of Component Parts or Modification** of a Prosthetic Device within five (5) years of obtaining a new or other replacement part(s) is **NOT COVERED** unless specifically provided for in Sections 3.6.4 and 3.6.4.1 of this Summary Plan Description.

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

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

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

4.65 Reversal of Genital Surgery. Surgical procedures to reverse genital surgery are **NOT COVERED**, except as stipulated in Section 4.56, **Service Provided in Conjunction with a Non-Covered Service**.

4.66 Reversal of Surgery to Revise Secondary Sex Characteristics. Surgical procedures to reverse secondary sex characteristic surgery are **NOT COVERED**, except as stipulated in Section 4.56, **Services Provided in Conjunction with a Non-Covered Service**.

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

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

SECTION 5. APPEAL PROCEDURE

APPEAL PROCEDURE. Requests for an appeal must be submitted **in writing** and received by the Claim Administrator 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 Claim Administrator 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 Indemnity Insurance Company
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 Summary Plan Description, the definition of Member shall include a Member's Authorized Representative. The Member shall be responsible to notify the Claim Administrator in writing of such designation. The Claim Administrator 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 Claim Administrator with written comments, documents, records or other information to be considered as part of the appeal review.

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

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

Pre-Service Appeal – Not later than 30 days after the Claim Administrator receives the written request
Post-Service Appeal – Not later than 30 days after the Claim Administrator receives the written request
Urgent Care Appeal – Not later than 72 hours after the Claim Administrator 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 Claim Administrator 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 Claim Administrator. The Claim Administrator will provide a full and fair review of the appeal.

5.1.1 **Pre-Service Appeal Review for Denials not based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the Claim Administrator or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the Claim Administrator. The Claim

Administrator shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.1.2 **Pre-Service Appeal Review for Denial Based on Medical Judgment**. A Pre-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the Adverse Benefit Determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the Claim Administrator shall provide the Member or the Health Care Provider with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the appeal. The Member and/or the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The Claim Administrator and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The Claim Administrator shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review meeting.

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

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

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

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

5.2.1 **Post-Service Appeal Review for Denials not based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the Claim

Administrator or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the Claim Administrator. The Claim Administrator shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

5.2.2 **Post-Service Appeal for Denials based on Medical Judgment.** A Post-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the Adverse Benefit Determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Member or a Health Care Provider with the Member's written consent, the Claim Administrator shall provide the Member or the Health Care Provider with access to the information relating to the matter being grieved at no cost and shall permit the Member and such Health Care Provider to provide additional verbal or written data or other material to support the appeal. The Member and the Health Care Provider who filed the appeal have the right to appear before the Internal Review Committee. The Claim Administrator and the Member have the right to be represented by an attorney or other individual before the Internal Review Committee. The Claim Administrator shall provide the Member and/or Health Care Provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review Committee meeting.

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

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

b) reference to the specific Plan 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

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

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

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

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

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

5.3.2 **Review of an Urgent Care Appeal.** The Claim Administrator shall perform an Urgent Care Appeal Review and render a decision within seventy two (72) hours of receipt of the Member's request. The Member shall be responsible to provide information to the Claim Administrator in an expedited manner to allow the Claim Administrator to conform to the Urgent Care Appeal requirements. The Urgent Care Internal Review Committee shall be comprised of three (3) or more individuals one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the Adverse Benefit Determination. The Urgent Care Appeal review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure, or provides the treatment and who was not previously involved in the matter under review. The Claim Administrator shall provide the Member with written notification of the Claim Administrator's decision that shall include:

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

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

5.4 External Appeal Review Procedure. If the Member is not satisfied with the Final Adverse Benefit Determination (a Final Adverse Benefit Determination is the decision made by the Claim Administrator in regard to an appeal filed in accordance with Sections 5.1, 5.2 or 5.3 above that results in a denial), the Member may have the opportunity to request an external review. Final Adverse Benefit Determinations that meet the federally regulated external appeal criteria are eligible for review by an IRO. Information regarding any appeal rights will be provided to the Member within the Appeal decision notification.

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

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

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

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

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

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

. Within one (1) business day after completion of the preliminary review, the Claim Administrator must issue written notification to the Member. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete. To complete an incomplete request, the Member will have either the remainder of the four (4) month filing period (as detailed in Section 5.4.1) or within forty-eight (48) hours following the receipt of the notification, whichever is later.

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

a) The Member's medical records;

b) The attending health care professional's recommendation;

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

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

e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed

by the Federal government, national or professional medical societies, boards, and associations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 6. ELIGIBILITY

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

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

a) a) (i) a full-time resident of the Service Area or (ii) work within the Service Area and live within twenty (20) miles or thirty (30) minutes of a Participating Primary Care Physician; and

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

c) a bona fide (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 Plan Sponsor or be entitled to coverage under a trust agreement and have satisfied any probationary or waiting period established by the Plan Sponsor; or

d) a former bona fide employee or member of a union, or the dependent of a former bona fide employee or member of a union, entitled under COBRA or other law, to participate in a program of health benefits arranged by the Plan Sponsor.

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

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

a) The spouse of a Subscriber under a legally recognized existing marriage under the laws of the Commonwealth of Pennsylvania is eligible for enrollment.

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

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

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

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

Eligibility shall cease for a dependent child on the last day of the month in which the dependent child becomes age 26(except for disabled dependent children). Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage and the applicable premium is duly paid.

6.2.1 **Newborn Child(ren).**

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

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

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

To have the newborn child of the Subscriber or the Subscriber's eligible dependent spouse covered as a Family Dependent under this Plan beyond the thirty-one (31) day period, the Subscriber must notify the Plan Sponsor that the newborn will be added to the Plan and pay any premium payment required for the addition of the newborn to the Plan.

Or

b) the newborn's parent(s), Legal Guardian, or Legal Custodian may convert to a separate individual policy, offering similar benefits to this Summary Plan Description, on behalf of the newborn.

It shall be the responsibility of the newborn's parent(s), Legal Guardian, or Legal Custodian to notify the Plan Sponsor of this choice within thirty-one (31) days from the newborn's birth.

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

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

An adopted child, or a child placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse is automatically covered under this Summary Plan Description for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from Single to Family Coverage) must be submitted to the Plan Sponsor within thirty-one (31) days of the date of adoption or date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. The Plan Sponsor will require documentary proof (i.e., official court

documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage.

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

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

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

In order to continue coverage of a disabled dependent child, the Subscriber must provide evidence to the Plan of the child's incapacity and dependency within thirty-one (31) days of the date the child's coverage would otherwise terminate. The Plan may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the Plan is first notified of such disability and dependency, whichever is earlier.

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

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

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

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

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

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

A full-time student under this Section shall mean:

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

(ii) who is either a high school student or enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

The Plan may periodically require documentary proof of enrollment as a student upon reaching the Maximum Age for dependent children set forth on the Summary of Benefits, or upon the date on which the Plan is first notified of such enrollment.

6.2.5 **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 (see section 6.2.7 below). The Subscriber must make written application for membership of such child. The Plan Sponsor will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty (30) days of receipt by the Plan of said official court order. The Subscriber shall notify the Plan Sponsor of the name and address of the custodial parent in order to allow the Plan Sponsor to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania. The Plan Sponsor may not disenroll or eliminate coverage of any child unless the Plan Sponsor 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.

6.2. **Qualified Medical Child Support Order.** A QMCSO is any judgment, decree, or order (including a court-approved settlement agreement) that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state; that assigns to a child the right of a plan participant or beneficiary to receive benefits under the plan, regardless of with whom the child resides; and that the Plan Sponsor has determined is qualified under the terms of ERISA and applicable state law. The Plan will comply with the terms of a QMCSO. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Sponsor determines that the order is a QMCSO. The Plan Sponsor will review the medical child support order to determine whether it meets the criteria for a QMSCO. If the Subscriber has questions about or would like to obtain a copy of the procedures governing a QMCSO determination, please contact the Plan Sponsor.

6.3 Employees on Military Leave. Subscribers going into or returning from military service may elect to continue coverage under the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights only apply to Subscribers and their Dependents covered under the Plan immediately prior to leaving for military service.

a) The maximum period of coverage of a Subscriber and a Subscriber's Dependents under an USERRA election shall be the lesser of:

(i) the 24 month period beginning on the date on which the Subscriber's absence begins; or

(ii) the day after the date on which the Subscriber was required to apply for or return to a position of employment and fails to do so.

(b) A Subscriber who elects to continue coverage under this Plan must pay up to 102% of the full contribution under the Plan, except a Subscriber on active duty for 30 days or less cannot be required to pay more than their pre-deployment share, if any, for the coverage.

(c) An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If a Subscriber would like to elect USERRA coverage or obtain more information, contact the Plan Administrator. The Subscriber may also have continuation rights under USERRA. In general, the Subscriber must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage for the Subscriber and their Dependents. Only the Subscriber has election rights, Dependents don't have any independent right to elect USERRA continuation.

The coverage will not include payment for injuries incurred in the line of military duty as set forth in Section 4.23 of this Summary Plan Description.

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 Summary Plan Description 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 Summary Plan Description 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 for up to the maximum period of time set forth under COBRA. The Plan Sponsor retains full responsibility for providing to Members all required notices and information relating to COBRA continuation coverage rights, as required by law. The Member should contact the Plan Sponsor for specific information on how to elect COBRA coverage and the associated costs of such coverage.

6.5 Effective Date(s) of Coverage. Individuals who meet the eligibility requirements under this Summary Plan Description 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 Plan Sponsor;

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 Summary Plan Description.

Only a Member for whom the premium is actually received by the Plan shall be entitled to coverage under this Summary Plan Description and only for the month for which such premium is received.

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

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

6.6 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the Plan by submitting a completed Enrollment

Application on forms provided by the Plan Sponsor. 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.

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.**

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

(i) termination of employment,
(ii) reduction in the number of hours of employment,
(iii) termination of the other program's coverage,
(iv) termination of contributions toward the premium made by the Group,
(v) death of a spouse, divorce, or legal separation,
(vi) exhaustion of the COBRA or Mini-COBRA maximum period of coverage (for COBRA or Mini-COBRA eligible Groups),
(vii) no longer working or residing in the service area when the other group health benefit program (such as HMO) does not provide benefits to an individual who no longer works or resides in the service area, or
(viii) loss of dependent status.

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

6.7.1.1 **Length of Special Enrollment Period**. A qualified individual or his or her dependent has thirty-one (31) days from the date of a qualifying event to apply for enrollment in this Plan.

6.7.2 **Special Enrollment Period - Medicaid and CHIP Eligibility and Premium Assistance.** An individual may enroll in the Plan at a time other than Open Enrollment if the Plan Sponsor 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 not later than sixty (60) days after the termination of coverage under the state Medicaid or CHIP program.

b) An individual or dependent has become eligible for a premium assistance subsidy for the Plan under a state Medicaid or CHIP plan. Such individual or dependent must request coverage

under the Plan not later than sixty (60) days after the individual or dependent is determined to be eligible for such assistance.

6.7.3 **Special Enrollment Period for Members who Lost Dependent Eligibility Status under the Plan Due to Age.** Effective March 23, 2010, any dependent child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under this Plan because, under the terms of the Plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 shall be eligible to (re)-enroll in the Plan. The Plan Sponsor shall provide the Subscriber with written notice of such opportunity to enroll a dependent child(ren). A Subscriber shall have sixty (60) days from such notice to enroll a dependent child(ren).

6.8 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 Plan unless they are covered under a continuation of benefits provision through another carrier or they are an admitted patient in a non Participating Provider facility who does not accept the Plan's terms and/or benefits. Expenses incurred prior to the effective date of enrollment in the Plan are **NOT COVERED**.

6.9 Continued Eligibility. Once enrolled, each Member must continue to meet the applicable eligibility criteria identified in this Summary Plan Description to continue as a Member. Loss of eligibility will result in termination of coverage.

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

6.11 The Family and Medical Leave Act. The Family and Medical Leave Act (FMLA) is a federal law that permits eligible employee Members to take up to twelve (12) weeks of unpaid, job-protected leave each twelve (12) month period for certain specified reasons. FMLA is applies to groups who employ fifty (50) or more employees each working day during twenty (20) or more calendar weeks in the current or preceding calendar year. FMLA only applies to eligible employees, i.e., those employees who have been employed by the employer for at least twelve (12) months and who have worked at least 1,250 hours in the twelve (12) month period immediately preceding the taking of FMLA leave. If the Member qualifies, they may take FMLA leave for any of the following reasons:

- the birth of a Member's child and care for that child;
- the placement of a child with the Member for adoption or foster care;
- to care for a Member's spouse, child or parent with a serious health condition;
- a serious health condition that makes the Member unable to perform their job; or
- to care for a qualifying military service member injured in the line of active duty (in this case, 26 weeks of leave is available per 12-month period).

During FMLA leave, the Member must be provided with the same health benefits that the Member was receiving immediately prior to their leave. Contact the Plan Sponsor for further information and instructions on how to apply for FMLA leave.

SECTION 7. LIMITATIONS

7.1 Circumstances Beyond Control. The Claim Administrator shall not be in violation of this Summary Plan Description 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 Claim Administrator is subject. In the event the Covered Services which the Claim Administrator has agreed to provide are substantially interrupted including, but not limited to, the significant partial destruction of the Claim Administrator's administrative offices, or a significant partial disability of the Network, pursuant to any such events, the Claim Administrator shall make a reasonable effort to arrange for an alternative method of providing care.

7.2 Coordination of Benefits.

7.2.1 **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 Summary Plan Description 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 Summary Plan Description. 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.

7.2.2 **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.

7.2.3 **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.

7.2.4 **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.

7.2.5 **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.

7.2.6 **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.

7.2.7 **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.

7.2.8 **Provisions of Covered Services.** This Plan shall provide health services first and then seek Coordination of Benefits.

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

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

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

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

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

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

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

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

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

7.2.9.2 **Double Coverage.** The benefits provided under this Summary Plan Description 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 Summary Plan Description 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.**

7.3 Subrogation and Reimbursement Rights.

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

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

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

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

7.3.3 Reimbursement Rights. If a Member obtains any recovery - regardless of how it is described or structured - from a Responsible Third Party, the member must fully reimburse GIIC on behalf of the Plan out of the amounts recovered from the Responsible Third Party for all medical expenses that were paid to the Member or on the Member's behalf to the extent permitted by law. GIIC on behalf of the Plan has the right to pursue recovery of the full reimbursement amount.

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

7.3.4 Relationship to ERISA Benefit Plan. If the SPD is incorporated into, and its terms made a part of, an employer-sponsored welfare benefit plan subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and if the employer sponsoring such welfare benefit plan has issued a written plan document or summary which contains subrogation or reimbursement provisions which are more favorable to GIIC on behalf of the the Plan than the provisions stated in the Subrogation Rights and Reimbursement Rights Sections, then the subrogation and reimbursement provisions set forth in such employer-issued plan document(s) will control with respect to GIIC on behalf of the Plan's right to pursue subrogation and reimbursement.

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

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

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

7.3.6 Obligations of a Member. A Member who asserts a claim against a Responsible Third Party must immediately notify GIIC on behalf of the Plan in writing of the claim, regardless of whether it is asserted informally or through judicial or administrative proceedings. Whenever a Responsible Third Party or its representative contacts a Member or the Member's representative, and whenever a Member contacts a Responsible Third Party or its representative for the purpose of discussing a potential settlement or resolution, the Member must immediately notify GIIC on behalf of the Plan in writing. A Member must refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury or illness for which the Plan provided medical care or any benefits in any way, unless and until GIIC on behalf of the Plan provides its written authorization to accept the offer. A Member must fully cooperate with GIIC on behalf of the Plan, as needed, to allow for the enforcement of these subrogation and reimbursement rights, promptly supply information/documentation when requested, and promptly execute any and all forms/documents that may be needed by GIIC on behalf of the Plan to fully exercise its reimbursement and subrogation rights. This includes providing GIIC on behalf of the Plan with any relevant information it requests, signing and delivering such documents as GIIC on behalf of the Plan or its agents reasonably request to secure the subrogation and/or reimbursement claim, providing testimony, and making court appearances. A Member must avoid taking any action that may prejudice or harm GIIC on behalf of the Plan's ability to enforce its subrogation and reimbursement rights to the fullest extent possible. A Member must fully reimburse GIIC on behalf of the the Plan promptly, if appropriate, out of the amounts recovered from the Responsible Third Party whether the funds are received by court judgment, settlement or otherwise from a Responsible Third Party. All of these obligations of a Member apply to the heirs, estate, legal guardians or legal representatives of the Member.

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

SECTION 8. TERM AND TERMINATION

8.1 **The Plan may be terminated for the following reasons.**

8.1.1 **Fraud or Material Misrepresentation by the Member.** If it is proven that the Member attempted or committed fraud under this Summary Plan Description to obtain benefits or payment or if the Member makes an intentional misrepresentation of material fact in the application for coverage under this Summary Plan Description, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber. For termination of coverage with a retroactive effect, thirty (30) days advance written notice will be provided to the Subscriber. This decision may be appealed through the Plan's established appeal procedure as set forth in Section 5 of this Summary Plan Description.

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

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

8.1.3 **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. Surviving Family Dependents may also be eligible to continue coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 8.2.

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

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

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

the Subscriber and all Family Dependents shall be terminated upon fifteen (15) days written notice by the Plan to the Subscriber.

8.2 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.

8.3 Health Status. Members enrolled under this Summary Plan Description will not have coverage terminated because of health status or requirements for health services.

9. GENERAL PROVISIONS.

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

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

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

a) verbally;

b) through an Advanced Health Care Directive; or

c) through a properly appointed surrogate.

9.4 Claims and Reimbursement.

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

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

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

To file a claim, the Member should call 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 Claim Administrator will issue payment to a provider or reimburse the Member for services received under this Summary Plan Description. The Member must complete a claim form for services rendered by a Non-Participating Provider and submit it, together with an itemized bill, to the following address:

Geisinger Indemnity Insurance Company
Claims

P.O. Box 853910
Richardson, TX 75085-3910

If a claim form is not received by the Member within fifteen (15) days of request to the Claim Administrator, 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 Indemnity Insurance Company
Claims
P.O. Box 853910
Richardson, TX 75085-3910

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.

9.4.2 **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 Claim Administrator will reimburse the Member by check immediately upon receipt of written proof of claim set forth under Section 9.4.1 of this Summary Plan Description. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the Claim Administrator 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 Summary Plan Description.

9.5 Amendments. The provisions of this Summary Plan Description cannot be altered or changed by any representative or agent of the Plan, other than by a written Amendment.

9.6 Authorization to Disclose Confidential Information. Subject to the medical records confidentiality provisions below, the Claim Administrator is entitled to receive from any provider of Covered Services to any Member, information reasonably necessary in connection with the administration of this Summary Plan Description.

9.6.1 **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 Claim Administrator concerning Members will be kept confidential to the extent required by law. Such records and other information will be disclosed by the Claim Administrator 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 Claim Administrator 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 Plan's quality improvement and medical management programs; and general administration of this Summary Plan Description and the Plan.

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

9.7 Enrollment Applications and Statements. Members or applicants for membership shall complete and submit to the Plan Sponsor such Enrollment Applications, or other forms or statements as the Plan Sponsor may reasonably request. Members and applicants for membership represent that all information contained in such Enrollment Applications, forms or statements submitted to the Plan Sponsor prior to enrollment under this Summary Plan Description 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.

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

9.9 Clerical Error. Clerical error, whether of the Plan Sponsor or the Claim Administrator, in keeping any record pertaining to the coverage under this Summary Plan Description will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

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

9.11 Notices. Any notice under this Summary Plan Description may be given by United States Mail, first class, postage prepaid, addressed as follows:

Muellers McDonalds
104 S State St.
Clarks Summit, PA 18411

Notice to a Member will be sent to the Member's last address known to the Plan Sponsor.

9.12 Substitution of Non-Covered Services. Other provisions of this Summary Plan Description notwithstanding, the Plan Sponsor reserves the right to provide any service, supply, equipment or benefit which is otherwise **NOT COVERED**, or which is limited or excluded, when, in the sole judgment of the Plan Sponsor, provision of such service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equivalent benefits available under this Summary Plan Description 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 Summary Plan Description at any time.

9.13 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.

9.14 Physical Examination. The Claim Administrator, at it 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.

9.15 Discretionary Authority. The Claim Administrator and the Plan Sponsor have full discretionary authority to make benefit and eligibility determinations and adjudicate claims under the Summary Plan Description.

9.16 Compliance with the Law; Amendment. Anything contained herein to the contrary notwithstanding, the Plan Sponsor 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 Summary Plan Description, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Summary Plan Description for any one (1) or more eligible Members enrolled under this Plan, and each party hereby agrees to any amendment of this Summary Plan Description 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.

9.17 Governing Law. This Summary Plan Description is subject to the laws of the Commonwealth of Pennsylvania and applicable Federal regulations including ERISA, USERRA and HIPAA. 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 Summary Plan Description shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

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

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

Examples of fraud and abuse are:

Examples of Fraud

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

Examples of Abuse

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

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

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

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

SECTION 10. PLAN INFORMATION AND ERISA RIGHTS

I. PLAN INFORMATION

1. **Name of Plan**: Muellers McDonalds

2. **Plan Sponsor Name, Address and Telephone Number:**
Muellers McDonalds
104 S State St.
Clarks Summit, PA 18411

3. **Employer Identification Number (EIN):** 23-1984690

4. **Plan Number:** 501

5. **Type of Plan:** HMO

6. **Plan Administrator's Name, Address and Telephone Number:**
Muellers McDonalds
104 S State St.
Clarks Summit, PA 18411

7. **Person designated as agent for service of legal process:** Christina Mueller

8. **Source of contribution under the Plan.** The Subscriber contributes towards the cost of coverage for themselves and their covered dependents. The medical and prescription drug coverage described in this Summary Plan Description are self-funded by the Plan Sponsor. This means that these benefits are paid by the Plan Sponsor out of its general assets. Any required employee contributions are used to partially reimburse the Plan Sponsor for self-funded benefits under this Plan.

9. **Date of the end of the year for purposes of maintaining the Plan's fiscal records.** The plan year shall be a twelve (12) month period ending September 30.

10. **Administration of the Plan.** [The Plan Sponsor provides certain administrative services in connection with this Plan. The Plan Sponsor may, in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including: access to a Network of Providers; claim processing services; utilization management and complaint resolution assistance.]

11. **Claims and Appeal Administrator.** The entity which provides certain administrative services for the Plan as identified below.

For Medical and Prescription Drug Claims:

Geisinger Indemnity Insurance Company
Claims
PO Box 853910
Richardson, TX 75085-3910

800-504-0443
www.thehealthplan.com

For Appeals:

Geisinger Indemnity Insurance Company
Appeal Department
M.C. 3220
100 North Academy Ave.
Danville, PA 17822-8200

II. STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information about the Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and upon written request at other specified locations, such as work establishments, all Summary Plan Descriptions, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

2. Continue Group Health Plan Coverage.

- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependent may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit

or exercising your rights under ERISA.

- The named fiduciary of this Plan is Plan Sponsor: Muellers McDonalds

4. Enforce Your Rights.

If your claim is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request Summary Plan Descriptions or an annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision concerning the qualified status of a medical support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT 1
SERVICE AREA

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

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

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

EXHIBIT 2
PREVENTIVE COVERED SERVICES

The following preventive health care Covered Services are covered under this Plan with no Cost Sharing (except for Multi Source Brand name drugs and devices as set forth in this Exhibit in Section 10 (a) (ii)) when obtained from a Participating Provider. Preventive services listed in Exhibit 4 obtained from a Non-Participating Provider are not covered.

The preventive Covered Services set forth in this Exhibit are subject to change upon revision of the services by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) (Immunization Practices), the Health Resources and Services Administration (HRSA) and the Institute of Medicine (IOM). For the most current list of preventive Covered Services please refer to: https://www.healthcare.gov/what-are-my-preventive-care-benefits.

NOTE:

(1) Some recommendations may have a future effective date and may therefore not be covered at no Cost Sharing until Benefit Periods beginning on or after that date.

(2) Health care services which are not preventive health care services as set forth in this Exhibit 2 but which may be rendered by a Participating Provider during a preventive office visit may be subject to applicable Cost Sharing by the Member.

1. **Periodic health assessments** including:

a) medical history;

b) 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, chlamydia screening (limited to women ages 16 – 25), gonorrhea screening and a screening Pap smear in accordance with the recommendations of the American College of Obstetrics and Gynecology and an annual gynecological examination including a pelvic examination and a clinical breast examination;

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 or age (see **NOTE** below);

e) screening for osteoporosis, which may include but is not limited to a DEXA scan (X-ray imaging test which measures bone density for osteoporosis); and

f) cholesterol screening and lipid panel;

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

2. **Well-child and/or pediatric care** which includes:

2.1 **pediatric and/or well-child care** including:

a) *oral fluoride supplementation for children between 6 months of age and age 6 as necessary;

b) medical history;

c) measurements including: height, weight, head circumference, body mass index and blood pressure;

d) sensory screening, which includes:

i) visual acuity screening and basic eye screening examinations to determine the need for further vision evaluation;

ii) basic hearing screening examinations to determine the need for further hearing evaluation;

e) developmental screening and surveillance;

f) autism screening;

g) psychosocial/behavioral assessment;

h) alcohol and drug use assessment;

i) physical examination;

j) lead screening;

k) tuberculin test;

l) dyslipidemia screening;

m) sexually transmitted infection screening;

n) cervical dysplasia screening;

o) primary care clinician application of fluoride varnish to the primary teeth of all infants and children from birth through age five (5) years starting at the age of primary tooth eruption.

p) vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.

2.2 **Newborn preventive services** which include:

a) one (1) hematocrit and one (1) hemoglobin screening for infants under twenty-four (24) months;

b) prophylactic eye medication for gonorrhea (gonococcal ophthalmia neonatorum);

c) hearing loss screening;

d) congenital hypothyroidism screening;

e) phenylketonuria PKU screening; and

f) National Newborn Inheritable Disease Screening Panels as recommended by the HHS Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC).

3. **Immunizations,** in accordance with accepted medical practices excluding immunizations necessary for international travel. Coverage shall be included for immunizations, including the immunizing agents as may be determined by the Pennsylvania Department of Health, the Patient Protection and Affordable Care Act (PPACA), applicable state and federal regulations and/or the Plan.

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

5. **Screening Services** which include:

a) **Colorectal cancer screening** which includes fecal occult blood testing; fecal immunochemical testing such as the Cologuard® test; flexible sigmoidoscopy; colonoscopy procedures; and CT colonography.

b) **Abdominal aortic aneurysm screening** for Members aged 65 and older with a history of smoking and/or family history of abdominal aortic aneurysm.

c) **Alcohol screening & counseling.**

d) **Blood pressure screening** for adults age 18 and older.

e) **Depression screening** for adolescents and adults ages 12 and older

f) **Human immunodeficiency virus (HIV) Annual Screening** for adolescents and adults**.**

g) **Obesity screening/counseling** for adults and children age 6 and older.

h) **Syphilis screening** as determined by the PCP or OB/GYN Participating Provider.

i) **Diabetes screening** of asymptomatic adults who meet criteria for increased diabetes risk as determined by the U.S. Preventive Services Task Force (USPSTF) and/or the PPACA.

j) **Cervical cancer.** Women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

Women age 21 and over are covered for high-risk human papillomavirus (HPV) DNA testing, regardless of pap-smear results. Testing is limited to one every three years.

k) **Screening and counseling for interpersonal and domestic violence.** Annual screening and counseling for interpersonal and domestic violence is covered for female Members.

l) **Hepatitis B screening**. Screening for hepatitis B virus infection in nonpregnant adolescents and adults at high risk for infection.

m) **Hepatitis C virus infection screening.** Screening for hepatitis C virus (HCV) infection in adults ages 18 to 79 years.

n) **Lung cancer screening**. Annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

o) **Tuberculosis Screening - Adults.** Screening for latent tuberculosis infection in populations at increased risk.

p) **Unhealthy Drug Use.** Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

6. **Pregnancy related Preventive Services which include:**

a) **Bacteruria screening** for pregnant women in the 12th through 16th week of gestation or during the first prenatal visit, if such a visit is later than the 12th – 16th week period.

b) **Iron deficiency anemia screening** in asymptomatic pregnant women.

c) **Rh (D) blood typing and antibody testing** for all pregnant women during the first prenatal visit and a repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks of gestation, as required.

d) **Syphilis screening** for all pregnant women.

e) **Interventions to support breast feeding** during and after birth.

f) **Tobacco use counseling.**

g) **Hepatitis B virus (HBV) screening** for pregnant women.

h) **Screening for gestational diabetes** is covered for pregnant women after 24 weeks of pregnancy and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

i) **Breastfeeding support, supplies, and counseling**. Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, and the costs for renting breastfeeding equipment are covered. These services are available for every birth a female Member has while covered under the Plan.

j) **Maternity care office visits.**

k) **Human immunodeficiency virus (HIV) screening** for pregnant women, including those who present in labor who are untested and whose HIV status is unknown.

l) **Preeclampsia screening** for pregnant women with blood pressure measurements throughout pregnancy.

7. **Counseling Preventive Services which include:**

a) **Counseling related to BRCA screening of women** is covered when the woman is referred for such screening or pre-screening evaluation.

b) **Counseling regarding chemoprevention of breast cancer** to inform Members of the potential benefits and harms of chemoprevention of breast cancer as necessary.

c) **Counseling for a healthy diet and physical activity.** Behavioral counseling to promote a healthy diet and physical activity for adults with hyperlipidemia and other known risk factors for cardiovascular disease.

d) **Counseling for sexually transmitted infections.** Annual counseling is covered for sexually active adolescents and adults.

e) **Counseling for human immune-deficiency virus (HIV)**. Annual Counseling is covered for human immune-deficiency virus (HIV) infection for all sexually active women.

f) **Skin cancer behavioral counseling.** Counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer for children, adolescents, and young adults ages 10 through 24 years.

8. **Over-the-counter preventive medications when ordered by a Healthcare Provider.** Such over - the - counter medications include:

a) ***Folic Acid** (containing 0.4 to 0.8 mg) as a daily supplement for women planning or capable of pregnancy.

b) ***Low dose Aspirin to aid in the prevention of Cardio Vascular Disease** (at 91.0 mg strength only) to aid in the prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

c) **Preeclampsia prevention**. The use of low-dose aspirin (81.0 mg/d) as a preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.

9. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

10. Female Contraceptive methods and counseling. All Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered as prescribed by the Member's Participating Provider.

a) **Contraceptive drugs and devices.** Contraceptive drugs and devices are covered subject to the Cost Sharing set forth below.

i. **Single Source Brand Name Drugs and Devices** (brand name drugs/devices without a generic equivalent) and generic drugs/devices are covered with no Member Cost Sharing.

ii. **Multi Source Brand Name Drugs and Devices** (brand name drugs/devices with a generic equivalent) are covered as per the Member's Prescription Drug Supplemental Health service, as set forth on the Summary of Benefits.

11. BRCA Test for Females.

12. Tobacco Use Screening and Counseling. Covered Services include two (2) tobacco cessation attempts per Benefit Period for those using tobacco products. A cessation attempt includes four (4) tobacco cessation counseling sessions of at least ten (10) minutes each. All FDA approved tobacco cessation medications (prescription and/or over-the-counter) are covered for a ninety (90)-day treatment regimen, limited to thirty (30)-day refills, and are subject to the Cost Sharing set forth below.

i. **Single Source Brand Name Drugs and Devices** (brand name drugs/devices without a generic equivalent) and generic drugs/devices are covered with no Member Cost Sharing.

ii. **Multi Source Brand Name Drugs and Devices** (brand name drugs/devices with a generic equivalent) are covered as per the Member's Prescription Drug supplemental health service or, for Members with no Prescription Drug supplemental health service, as set forth on the Summary of Benefits.

13. **Generic Raloxifene, Generic Tamoxifen, and Generic Aromatase Inhibitors for breast cancer prevention in females.**

14. **Bowel Preparation Medications for Preventive Screening Colonoscopies**. Single Source Brand Name Drugs (brand name drugs without a generic equivalent) and generic drugs are covered with no cost sharing for members starting at age 45 and continuing until age 75 years.

15. **Statin Use for the Primary Prevention of Cardiovascular Disease in Adults:** The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low-to-moderate dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

    Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years.

16. **Pre-exposure Prophylaxis (PrEP):** The USPSTF recommends PrEP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

    *A written or oral prescription for the above *indicated medications must be provided by a Participating Provider and presented to a Participating or Participating Mail Order Pharmacy for coverage by the Plan.

EXHIBIT 3
NON-PARTICIPATING PROVIDER COST SHARING EXAMPLE CHART

As Described in Section 1.8, when using a Non-Participating Provider, any costs that exceed the Plan's Non-Participating 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 Plan's Non-Participating Provider Fee Schedule Amount and the Non-Participating 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	**Plan Pays**
Provider's Charges	$10,000		
Plan Allowed Amount	$3,000	$7,000 (Provider charges, less Plan allowed amount)	
Deductible	$250	$250	
Coinsurance ($2,750 at 10%)	10%	$275	
Plan 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 Summary of Benefits for the specific Deductible, Coinsurance and/or Copayment amounts which are applicable to this Summary Plan Description.

EXHIBIT 4
SUPPLEMENTAL HEALTH SERVICE RIDERS

The following Supplemental Health Services are covered as part of this Summary Plan Description. Please refer to the terms and conditions of each Supplemental Health Services for specific coverage and exclusions.

Autism Spectrum Disorder Services
Supplemental Health Service

1. **DEFINITIONS**. The following definitions shall apply:

1.1 **Applied Behavioral Analysis** means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

1.2 **Autism Spectrum Disorder** means any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

1.3 **Autism Spectrum Disorder Provider** means a Pennsylvania licensed or certified person, entity or group providing Treatment of Autism Spectrum Disorders pursuant to a Treatment Plan.

1.4 [**INTENTIONALLY LEFT BLANK**]

1.5 **Participating Pharmacy** means a pharmacy which has in effect on the date of service, an agreement with the Claims Administrator to provide prescription drugs to Members and is so designated by the Claims Administrator. For pharmacies that are not in the Plan's Service Area, prescription drugs or refills may be filled at pharmacies contracted through the Plan's pharmacy claims processor.

1.6 **Treatment of Autism Spectrum Disorders** shall be identified in a Treatment Plan and shall include any Medically Necessary Pharmacy Care Services, Psychiatric Care Services, Psychological Care Services, Rehabilitative Care Services and Therapeutic Care Services that are:

a) prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner;

b) provided by an Autism Spectrum Disorder Provider;

c) provided by a person, entity or group that works under the direction of an Autism Spectrum Disorder Provider.

1.7 **Treatment Plan** means a plan for the Treatment of Autism Spectrum Disorders which is developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The Plan may review a Treatment Plan for Treatment of an Autism Spectrum Disorder once every six (6) months subject to its utilization review requirements. A more or less frequent review can be agreed upon by the Plan and the licensed physician or licensed psychologist developing the Treatment Plan.

2. **BENEFITS.**

2.1 **[INTENTIONALLY LEFT BLANK]**

2.2 **Autism Spectrum Disorder Services.** Coverage for Autism Spectrum Disorder Services is provided to Members under twenty-one (21) years of age for the diagnostic assessment of Autism

Spectrum Disorders and for the Treatment of Autism Spectrum Disorders when provided by an Autism Spectrum Disorder Provider. Such assessment and treatment may include the following Medically Necessary services consistent with the specific requirements set forth below.

2.2.1 **Pharmacy Care Services.** Pharmacy Care Services include medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. Prescriptions for prescribed medications must be obtained from a Participating Pharmacy.

2.2.1.1 **Cost Sharing.** Pharmacy Care Services Cost Sharing shall be as follows:

a) For Members with an Outpatient Prescription Drug supplemental health service, Pharmacy Care Cost Sharing shall be that indicated on the Summary of Benefits for the Outpatient Prescription Drug supplemental health service.

b) For Members without Outpatient Prescription Drug coverage, the Pharmacy Care Cost Sharing shall be 50% Coinsurance.

2.2.2 **Psychiatric Care Services.** Psychiatric Care Services include direct or consultative services provided by a physician Autism Spectrum Disorder Provider who specializes in psychiatry. Psychiatric Care Services must be provided by an Autism Spectrum Disorder Participating Provider.

2.2.2.1 **Cost Sharing.** Psychiatric Care Services Cost Sharing shall be the Copayment set forth on the Summary of Benefits, listed under "Mental Health Services" as the "Outpatient Professional Services" Copayment.

2.2.3 **Psychological Care Services.** Psychological Care Services include direct or consultative services provided by a psychologist Autism Spectrum Disorder Provider. Psychological Care Services must be provided by an Autism Spectrum Disorder Provider.

2.2.3.1 **Cost Sharing.** Psychological Care Services Cost Sharing shall be the Copayment set forth on the Summary of Benefits, listed under "Mental Health Services" as the "Outpatient Professional Services" Copayment.

2.2.4 **Rehabilitative and Habilitative Care Services.** Rehabilitative and habilitative care services include professional Autism Spectrum Disorder Provider services and treatment programs, including Applied Behavioral Analysis (see **NOTE** below), provided to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. Rehabilitative Care Services must be provided by an Autism Spectrum Disorder Provider.

2.2.4.1 **Cost Sharing**. Rehabilitative and habilitative care services Cost Sharing for services received from a Participating Provider shall be that set forth on the Summary of Benefits, listed under "Physician Office Services" as the "Therapy Office Visit" Copayment.

2.2.5 **Therapeutic Care Services.** Therapeutic Care Services require Prior Authorization by the Plan and include services provided by speech language pathologist, occupational therapist or physical therapist Autism Spectrum Disorder Providers. Therapeutic Care Services must be provided by a Participating Provider.

2.2.5.1 **Cost Sharing**. Therapeutic Care Services Cost Sharing for services received from a Participating Provider shall be that set forth on the Summary of Benefits, listed under "Physician Office Services" as the "Specialist Office Visit" Copayment.

2.3 **Expedited Review**. Upon the Plan's denial of a Member's claim for diagnostic assessment or Treatment of Autism Spectrum Disorder, a Member or a Member's Authorized Representative shall be entitled to the expedited internal review process consistent with the Expedited Grievance Review Procedure set forth in the SPD. Any external review disapproving a denial or partial denial may be appealed to a court of competent jurisdiction.

3. **BENEFIT LIMIT.**

3.1 **Benefit Limits Listed on the Summary of Benefits**. Benefit Limits set forth on the Summary of Benefits are not applicable to the Autism Spectrum Disorder services covered by this herein.

4. **EXCLUSIONS.**

4.1 Psychiatric Care Services, Psychological Care Services and Rehabilitative Care Services obtained from Participating Providers **NOT COVERED. ***

4.2 Pharmacy Care Services obtained from non–Participating Pharmacy Providers are **NOT COVERED.**

4.3 Therapeutic Care Services obtained from a Non-Participating Provider are **NOT COVERED**.*

NOTE: Applied Behavioral Analysis services require Prior Authorization as set forth in the SPD.

Manipulative Treatment Services
Supplemental Health Service

Manipulative Treatment Services must be obtained from a Participating Provider.

1. **DEFINITIONS.** The following definitions shall apply:

1.1 **Appliances** mean support type devices prescribed by a Participating Provider. These shall be restricted to the following items to the exclusion of all others: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, support/lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

1.2 **Manipulative Treatment Services** mean those services rendered or made available to a Member by a Participating Provider for treatment or diagnosis of Neuromusculoskeletal Disorders.

1.3 **Neuromusculoskeletal Disorders** mean conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

2. **BENEFITS**.

2.1 **Manipulative Treatment Covered Services.** Subject to the Cost Sharing amount as set forth on the Summary of Benefits and Benefit Limits set for herein, the following Manipulative Treatment Services are covered only when obtained from a Participating Provider

a) **New Patient Examination.**

b) **Established Patient Examination.**

c) **Subsequent Office Visits.**

d) **Adjunctive Therapy.** Adjunctive therapy may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.

e) **X-rays.** X-rays are covered when provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which participates in the Network.

f) **Appliances.** Appliances are covered up to a Benefit Limit of $50.00 per Benefit Period when prescribed by a Participating Provider.

g) **Approval.** All services must be approved by the Plan as Medically Necessary for treatment of Neuromusculoskeletal Disorders.

3. **COST SHARING.**

3.1 **Copayment**. New patient examinations, established patient examinations and subsequent office visits are subject to the applicable Primary Care Physician office visit Copayment set forth on the Summary of Benefits.

3.2 **Benefit Limit.** Manipulative Treatment Services provided hereunder to any Member shall be limited to fifteen (15) visits each Benefit Period. Members must pay for any Manipulative Treatment Services received above this Benefit Limit.

4. **EXCLUSIONS.** The following are not covered hereunder:

4.1 Services from a Participating Provider for examinations and/or treatments for conditions other than those related to Neuromusculoskeletal Disorders;

4.2 Hypnotherapy, behavior training, sleep therapy and weight programs;

4.3 Thermography;

4.4 Services, lab tests, x-rays and other treatments which are documented as classified, experimental or investigational and/or being in the research stage;

4.5 Magnetic Resonance Imaging (MRI), Computed Axial Tomography (CAT) scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies;

4.6 Transportation costs including local ambulance charges;

4.7 Education programs, non-medical self-care or self-help or any self-help physical exercise training or related diagnostic testing;

4.8 Services or treatments for pre-employment physicals or vocational rehabilitation;

4.9 Services or treatments for sickness or injury covered by a worker's compensation act or occupational disease law or by United States Longshoreman's and Harbor Worker's Compensation Act;

4.10 Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all Appliances, except as described in Section 2, Benefits;

4.11 Durable Medical Equipment;

4.12 Prescription drugs or medicines;

4.13 Hospitalization, anesthesia, manipulation under anesthesia and other related services;

4.14 Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;

4.15 Adjunctive therapy not associated with spinal, muscle or joint manipulation;

4.16 Vitamins, minerals or other similar products; and

4.17 Manipulative Treatment Services which are not obtained from a Participating Provider.

Supplemental Generic
Outpatient Prescription Drugs - With Contraceptives
Three Tier Supplemental Health Prescription Benefit

Outpatient Prescription Drugs may be prescribed by either a Participating or Non-Participating Provider, but must be obtained from a Participating Pharmacy or Participating Mail Order Pharmacy.

1. **DEFINITIONS.** The following definitions shall apply:

1.1 **Brand Name Drug** as used herein means a medication for which there is not an AB-rated Generic equivalent available or the non-Generic form of a medication when a Generic is available.

1.2 **Drug Formulary or Formulary** means a continually updated list of prescription medications that represents the current covered drugs by the Plan based upon the clinical judgment of the Claims Administrator's Pharmacy and Therapeutics Committee. The Drug Formulary contains both Brand Name Drugs and Generic Drugs, all of which have been approved by the U.S. Food and Drug Administration (FDA). A current list of drugs included on the Drug Formulary is provided when the Member becomes covered under the SPD and this supplemental health service. Subsequent updates to the Formulary may be obtained by contacting the Plan at the phone number on the back of the Member's Identification Card or can be viewed on the Plan's Web site at www.GeisingerHealthPlan.com.

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

1.4 **Generic Drug or Generic** means a Prescription Drug that is (i) permitted under applicable law; (ii) so designated as a chemical equivalent product substitution and set forth in the manual published by the United States Health and Human Services entitled, "Approved Drug Products with Therapeutic Equivalence Evaluations" (the "Orange Book"); or (iii) designated as a Generic by another third party, selected at the Plan's sole discretion, such as the First Data Bank; and (iv) approved by the Plan.

1.5 **Mail Order Prescription Drug** means any Maintenance Prescription filled through the Claims Administrator's Mail Order Prescription Drug Program.

1.6 **Maintenance Prescription** means any Prescription Drug that is available through the Participating Mail Order Pharmacy and that would be taken on an ongoing basis to treat a chronic condition.

1.7 **Non-Formulary Brand Name Drug** as used herein, means a Brand Name Drug not listed in the Plan's Drug Formulary.

1.8 **Participating Mail Order Pharmacy** means a pharmacy that has in effect on the date of service, an agreement with the Claims Administrator to provide Mail Order Prescription Drugs to Members under the provisions of this supplemental health service, and is so designated by the Plan.

1.9 **Participating Pharmacy** means a pharmacy which has in effect on the date of service, an agreement with the Claims Administrator to provide Prescription Drugs to Members under the provisions of this supplemental health service, and is so designated by the Plan.

1.10 **Prescription Drug** means any drug or medicine required by Pennsylvania or Federal law to be dispensed by a licensed pharmacist or physician, upon written or oral prescription of a physician and which is prescribed for use as an outpatient. Prescriptions requiring compounding will be covered if they contain one or more medications required by Pennsylvania or Federal law to be dispensed only by prescription and must be approved by the Plan. Prescription Drug does not include those drugs expressly excluded under Section 6.

1.11 **Supplemental Generic Drug** means a Generic Prescription Drug or Generic Mail Order Prescription Drug listed in Section 1.11.1 below which is prescribed for outpatient use for the following medical conditions: a) coronary artery disease, b) depression, c) diabetes and d) hypertension. Supplemental Generic Drugs are not Formulary drugs as defined herein.

1.11.1 **Listing of Supplemental Generic Drugs**. The following are considered by the Plan to be Supplemental Generic Drugs.

a) Supplemental Generic Drugs for coronary artery disease are: Gemfibrozil, Pravastatin and Simvastatin.

b) Supplemental Generic Drugs for depression are: Citalopram, Fluoxetine, Sertraline and Venlafaxine (plain, not extended or sustained release).

c) Supplemental Generic Drugs for diabetes are: Glipizide, Glipizide XL, Glipizide/Metformin combination, Glyburide, Glyburide- micronized/Metformin combination, Metformin and Metformin ER.

d) Supplemental Generic Drugs for hypertension are: amlodipine, Atenolol, Hydrochlorothiazide, Lisinopril, Lisinopril/Hydrochlorothiazide combination and metoprolol tartrate.

Please note that Supplemental Generic Drugs may be added by the Plan as set forth herein.

2. **PRESCRIPTION DRUG TIERS.** Prescription Drug Tiers are subject to the Copayment or Coinsurance amounts as set forth on the Summary of Benefits. Drugs in each tier may require Prior Authorization in order for the drugs to be Covered Services. Please refer to Section 5.2 herein.

1st Tier - This includes most Generic Drugs and all of the Supplemental Generic Drugs. Prior Authorization is generally not necessary for drugs in this tier.

2nd Tier- This includes certain Generic Drugs as well as Formulary Brand Name Drugs with no Generic Drug equivalent. Prior Authorization may be necessary for coverage of certain drugs in this tier.

3rd Tier- This includes certain Formulary Brand Name Drugs with a Generic Drug equivalent and Non-Formulary Brand Name Drugs. It may also include certain Generic Drugs on occasion. Prior Authorization may be necessary for coverage of certain drugs in this tier.

3. **BENEFIT.**

3.1 Subject to the Cost Sharing amounts as set forth on the Summary of Benefits, and the Limitations as set forth herein, Formulary Prescription Drugs prescribed for a Member as a result of Covered Services provided and covered under the terms of the SPD are covered when provided by a Participating Pharmacy and/or Participating Mail Order Pharmacy, as applicable.

3.2 Subject to the Cost Sharing amounts as set forth on the Summary of Benefits, and the Limitations as set forth herein, restricted drugs and certain drugs requiring Prior Authorization prescribed for a Member as a result of Covered Services provided and covered under the terms of the SPD to which this supplemental health service is annexed, are covered only upon Prior Authorization by the Plan and provided by a Participating Pharmacy and/or Participating Mail Order Pharmacy, as applicable.

3.3 Human growth hormone covered herein is subject to the Coinsurance amount as set forth on the Summary of Benefits.

3.4 Certain retail Participating Pharmacy Providers may have agreed to make Maintenance Prescription Drugs available pursuant to the same terms and conditions, including Cost-Sharing and quantity limits, as the Mail Order Prescription drug coverage available herein. Members may contact the toll-free number appearing on the back of the Member's Identification Card for a listing of those retail Participating Pharmacy Providers who have agreed to do so.

4. SUPPLEMENTAL GENERIC DRUGS.

4.1 Subject to the Cost Sharing amounts set forth below in Section 4.3 and on the Summary of Benefits and the Limitations as set forth herein, Supplemental Generic Drugs prescribed for a Member are covered when the Member has been diagnosed with one of the medical conditions listed in Section 1.11. Supplemental Generic Drugs must be provided by a Participating Pharmacy and/or Participating Mail Order Pharmacy.

4.2 Supplemental Generic Drugs include the drugs listed in Section 1.11.1. Additional Supplemental Drugs may be added by the Plan. A current list of Supplemental Generic Drugs can be obtained by requesting a list from the Customer Service Team at the telephone number on the back of the Member's Identification Card or on the Plan's Web site atwwww.GeisingerHealthPlan.com. .

4.3 **Cost Sharing.** Supplemental Generic Drugs are provided to the Member at no cost once the Member has met his/her Prescription Drug Deductible (if applicable) as set forth on the Summary of Benefits. Cost Share for certain medications may be set higher than standard Cost Share in order to reduce pharmacy costs by obtaining the maximum coupon assistance from manufacturer programs. Actual Member Cost Share will be adjusted to the Member's regular medication Cost Share so the Member's actual out-of-pocket amount will remain the same or lower. Where applicable, and as allowed by state and/or federal law, the value of any manufacturer coupon assistance will not apply towards the accumulator total of the Member's annual Deductible or Maximum Out-of-Pocket. Only the Member's actual amount paid after the coupon assistance will be applied to the Member's annual Deductible or Maximum Out-of-Pocket

5. LIMITATIONS.

5.1 **Quantity.** Notwithstanding the limitation set forth in Section 5.1.1 specific to Mail Order Prescription Drugs, the maximum quantity of any drug covered hereunder, per prescription or refill, is limited to not more than a quantity which will be used within a three-month period. Vacation overrides are at the Plan's discretion. Additional quantity restrictions may apply in accordance with the Formulary or herein.

5.1.1 **Mail Order Prescription Drugs – Quantity**. The maximum quantity of any Mail Order Prescription Drug covered under this Rider, per Prescription Drug or refill, is limited to not more than a quantity which will be used within a three-month period. Additional quantity restrictions may apply in accordance with the Formulary and/or according to the terms and conditions of this Rider. 4th Tier drugs, as referenced in Section 2, may not be obtained by Mail Order.

5.2 **Drugs Requiring Prior Authorization.** Some drugs require Prior Authorization by the Plan in order for the drugs to be Covered Services. These drugs are identified in the Drug Formulary. Requests for Prior Authorization must be directed to the Plan's Pharmacy Services Team.

5.3 **Non-Formulary Drugs**. Certain Prescription Drugs may not be included on the Drug Formulary. Prior Authorization by the Plan is required for drugs not included on the Drug Formulary.

5.4 **Prenatal Vitamins and Fluoride.** A maximum of: (i) 100 tablets or capsules; or (ii) 50 ml in original package sizes of prenatal vitamins and vitamin fluoride combinations may be dispensed per Copayment or Coinsurance.

5.5 **Manufacturer.** The Plan reserves the right to restrict the manufacturer of Prescription Drugs covered herein. Such restriction is subject to change by the Plan without the consent or concurrence of the Members, except as provided for herein.

5.6 **Assignment of Drugs to Tiers.** The Plan reserves the sole discretion in assigning drugs to certain tiers and in moving drugs from tier to tier. Several factors are considered when assigning drugs to tiers, including but not limited to: (i) the availability of a Generic equivalent; (ii) the absolute cost of the drug; (iii) the cost of the drug relative to other drugs in the same therapeutic class; (iv) the availability of over-the-counter alternatives; and/or (v) clinical and economic factors.

5.7 **Cost Sharing and Benefit Limit.** Prescription Drugs covered hereunder shall be subject to the applicable Cost Sharing, Benefits, and Limitations described in Sections 2, 3 and 5 herein and as set forth on the Summary of Benefits.

Cost Share for certain specialty medications may be set higher than the standard Cost Share for specialty drugs in order to benefit from maximum coupon assistance from manufacturer programs to help reduce pharmacy costs. Actual Member Cost Share will be adjusted to the Member's regular specialty medication Cost Share, so the Member's actual out-of-pocket amount will remain the same or lower.

5.8 **Own Use.** Prescription Drugs covered hereunder shall be solely for the use of the Member for whom the drugs were prescribed.

6. **EXCLUSIONS.** The following are **NOT COVERED**:

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

6.2 **Devices.** The following non-contraceptive and contraceptive devices are not covered:

6.2.1 **Non-contraceptive Devices**. Devices of any type, even if such devices may require a prescription, including but not limited to: therapeutic devices, artificial appliances, hypodermic needles and syringes (except those which are listed as a Covered Service in the SPD at Section 3.3.1, Diabetic Medical Equipment), diagnostic devices and supplies.

6.2.2 **Non-Prescription and/or Non-FDA Approved Contraceptive Devices.** Non-prescription contraceptive devices and/or non-FDA Approved contraceptive devices, including but not limited to male condoms and implantable devices for the purpose of releasing contraceptive drugs.

6.3 Experimental drugs and/or devices, including those labeled "Caution-limited by Federal law to Investigational Use," non-FDA approved drugs and/or devices, FDA approved drugs for investigational indications or for non-FDA approved uses or at investigational doses and drugs and/or devices found by the FDA to be ineffective.

6.4 Prescription Drugs prescribed for weight loss or weight management.

6.5 Over-the-counter drugs and other items available without a prescription, whether provided with or without a prescription, including but not limited to aspirin, oxygen, cosmetics, medicated soaps, food supplements, vitamins and bandages (except for those over-the-counter medications listed in Section 3.4).

This does not include those over-the-counter medications listed in Preventive Covered Services Exhibit of the SPD.

6.6 Restricted drugs or drugs requiring Prior Authorization by the Plan which have not received such authorization in advance. The Plan reserves the right to require Prior Authorization for selected drugs (listed in the Drug Formulary) before providing coverage for such drugs.

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

6.8 Prescription Drugs not accepted as standard medical treatment of the condition being treated as determined by the Plan, or any such drug requiring Federal or other governmental agency approval not granted at the time the drug was dispensed.

6.9 Prescription Drugs prescribed for cosmetic indications, including but not limited to: drugs for hair loss or growth, drugs for wrinkles or skin bleaching and, drugs used for the treatment of onychomycosis (fungal nail infection) other than oral terbinafine.

6.10 Dietary supplements, vitamins (except prescription prenatal), fluoride supplements/rinses, (except for those over-the-counter medications listed in Section 3.4), anabolic steroids, blood plasma products or irrigation solutions.

6.11 Insulin and oral pharmacological agents for controlling blood sugar; disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips) which are covered as a Covered Service under Sections 3.3.1 and 3.3.3 of the SPD as part of Diabetic Medical Equipment, Supplies, Prescription Drugs and Services.

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

6.13 Erectile dysfunction medications and medications to treat female sexual dysfunction, including but not limited to hypoactive sexual desire disorder (HSDD) and dyspareunia.

6.14 Immunizations, except those which are covered as Covered Services under Exhibit 2 of the SPD as Preventive Services. Only certain vaccines are available through outpatient pharmacies.

6.15 Allergy injections.

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

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

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

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

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

6.21 Prescription Drugs which contain the active ingredients buprenorphoine/naloxone or buprenorphine are **NOT COVERED** unless they are prescribed by a Participating Provider.

6.22 Prescription bandages and other wound dressing products.

6.23 Use of a Prescription Drug by anyone other than the Member listed on the prescription.

6.24 Medications that are repackaged by the supplier and sent to the pharmacy for fulfillment of prescriptions.

6.25 Drugs prescribed or administered by a dentist for in dental office use are not covered except for those which are covered under SPD Section 3.11, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care.

6.26 Any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include those formulae which are covered under the terms and conditions of SPD Section 3.22, Medical Foods.

EXHIBIT 5
SUMMARY OF BENEFITS

[INSERT SUMMARY]

Geisinger Indemnity Insurance Co. : HMO Plan
Summary of Benefits
Muellers McDonalds

Deductible

$500 single
$1,000 family

Deductible must be satisfied every coverage period before coinsurance applies.
Copayments do not apply to the deductible.

Coinsurance

0%

Coinsurance Maximum

$0 single
$0 family

Deductible does not apply to coinsurance maximum.

Maximum Out of Pocket

$8,700 single
$17,400 family

Services covered when medically necessary	You Pay
Outpatient Physician Services	
Primary care office visits (PCP).	$20
Periodic health assessments/routine physicals.	$0
Specialist office visit.	$40
Telehealth (virtual visit)	
Primary care physician	$5
Specialist physician	$10
Behavioral health and substance abuse therapy	$5
Emergency Services	
Emergency care.	$75 (waived if admitted to hospital)
Emergency ambulance transportation.	$0
Critical response air transport.	$0
Urgent care.	$20
Preventive Services: For a Full list of preventive services refer to healthcare.gov/coverage/preventive-care-benefits. All PPACA Preventive Services including but not limited to:	
Mammograms.	$0
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0
Pap smears.	$0
Chlamydia screening ages 16-25.	$0
Dexa scan.	$0
Fecal occult blood testing.	$0
Cholesterol screening.	$0
Diabetes care including HbA1c testing, LDL-C screening and nephropathy screening.	$0

Lipid panel.	$0
Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.	$0
Well-Child Services	
Well-child office visits (age 0-21)	$0
Well-Woman Care	
Annual gynecological examination, including pelvic examination and routine pap smears. Includes appropriate follow-up care and referrals for diagnostic testing and treatment services relating to gynecological care.	$0
Outpatient Services.	
Outpatient surgery.	0% after deductible
X-rays, laboratory, and diagnostic tests.	0% after deductible
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology.	0% after deductible
Ostomy supplies.	0% after deductible
Urological supplies.	0% after deductible
Other diagnostic services.	0% after deductible
Colorectal Cancer Screening	
Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related services covered 100%. Note: preparation medication is not covered under the medical benefit. However, preparation medication may be covered under your pharmacy benefit, which will be subject to your normal pharmacy benefit cost-sharing.	$0
Maternity Care	
Maternity care by your physician before and after the birth of your baby. No referral required.	$0
Maternity hospitalization.	0% after deductible
Hospitalization...	
Medical and surgical specialist care, including anesthesia.	0% after deductible
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, medications, diagnostic tests and transplant services.	0% after deductible
Surgery for Correction of Obesity (cost sharing does not apply to maximum out-of-pocket)	
Facility charges.	$2,000
Professional charges.	0% after deductible
Rehabilitation Services	
Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	$40 per series
Spinal injections for back pain	0% after deductible, if coinsurance 0% then 30% coinsurance applies
Physical, Occupational and Speech Therapy	$40
Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year.	$0

Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year	$0
Diabetes Services and Supplies [1]	
Diabetic eye examination.	$0
Prescription/supply coverage: LifeScan test strips (OneTouch, OneTouch Ultra, and OneTouch Verio) and lancets are covered. The following may be limited to specific vendors: insulin, syringes and needles for the administration of insulin only, oral agents used to control blood sugar (1 copayment/34 day supply) and Glucagon emergency kit (two per copayment).	$0 single $0 family deductible which must be met first then Tier 1: $25 for 34-day supply Tier 2: $50 for 34-day supply Tier 3: $70 for 34-day supply
Diabetic foot orthotics.	0% after deductible
Home blood glucose monitors: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0
[1] The Plan reserves the right to restrict vendors and apply quantity limitations.	
Skilled Nursing/Home Health Services	
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.	0% after deductible
Home health care	$0
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	$0
Implanted Devices (medical and contraceptive)	
Drug delivery.	50%
Contraceptives	$0
Specialty Drugs	
For select high-cost specialty drugs. $1,500 maximum out-of-pocket per benefit year. (cost sharing for drugs obtained from a specialty vendor will follow the pharmacy benefit)	$150 per injection/infusion
Durable Medical Equipment	
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.	$0
Prosthetic Devices	
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.	$0
Orthotic Devices	
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50%
Alcohol and Drug Abuse Treatment	
Inpatient detoxification.	0% after deductible
Non-hospital residential inpatient rehabilitation.	0% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$20 individual therapy session /$20 group therapy session
Outpatient Opioid Detoxification Treatment	

Buprenorphine and buprenorphine/naloxone are covered as part of this treatment if the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member does not have a GHP drug rider, the detox sessions are covered but buprenorphine or buprenorphine/naloxone are not covered.	0% after deductible
Mental Health	
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	$20/individual therapy session $20/group therapy session
Serious Mental Illness (SMI) Services	
Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	0% after deductible/ inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day
Non-Serious Mental Illness Services	
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	0% after deductible inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day
Autism Spectrum Disorder Rider	
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.	
Pharmacy care	Copayment per outpatient prescription drug rider or 50% coinsurance for members with no prescription drug rider
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$20 individual therapy session /$20 group therapy session
Rehabilitative Care: professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.	$40 per day
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$40 per day

Additional Services	**You Pay**
Triple Choice Option for Outpatient Prescription Drugs [2]	
34-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug is assigned to a tier. Tier 1: most generic drugs; prior authorization is generally not required. Tier 2: certain generic drugs and formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents, other brand name drugs, and non-formulary drugs if approved; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861.	$0 single $0 family deductible which must be met first then Tier 1: $25 for 34-day supply Tier 2: $50 for 34-day supply Tier 3: $70 for 34-day supply
Contraceptives; includes diaphragms.	Copayment amount depends on tier for 34-day supply
Mail Order Pharmacy. Prescriptions can be received through the mail by using the Plan's mail order pharmacy program. A doctor's prescription, copayment and completed form is required.	2 1/2 flat copays amount(s) depending on tier/3-month supply
[2]The Plan reserves the right to restrict vendors and apply quantity limitations.	
Select Free Generic Drug Program	
Members will pay a $0 copay for certain generic drugs as part of Tier 1. All other Tier 1 drugs will have applicable copay applied. Deductible applies first, if applicable.	$0
Manipulative Treatment Services Rider	
Direct access to participating providers for chiropractic services which may include patient exams, manipulation, adjunctive therapy and X-rays. Chiropractic appliances covered up to	$20

$50 per benefit year when prescribed by a participating provider. Maximum 15 visits/benefit year.	
Refraction Rider	
One eye exam per year to determine the refractive error of the eye.	$0
Impacted Wisdom Teeth Extraction Rider	
Oral surgery by participating provider for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered without a prior-authorization.	$0
Please review individual rider documents for limitations and exclusions.	

Additional Discounts

Through our Accessories Program, you have access to money-saving discounts on a host of health-related products and services, with no referral necessary.

Acupuncture	Chiropractic care	Eyewear and eye exams
Fitness centers memberships	LASIK vision correction	Mail order contact lenses
Massage therapy	Safe Beginnings ®	

Member Information

We want our members to be well informed. The following information is available by contacting our Customer Care Team at (800) 504-0443.

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

Important information, definitions, and limitations

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

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

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

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

Covered services Covered services that are not available within the Plan's network or are out of the Plan's service area must be authorized in advance by the Plan.

Medical Necessity or Medically Necessary covered services rendered by a health care provider that the Plan determines are: a) appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; b) provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease or injury; c) in accordance with current standards of medical practice; d) not primarily for the convenience of the member, or the member's provider; and e) the most appropriate source or level or service that can safely be provided to the member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

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

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

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

:Muellers McDonalds:SOLO51 gen. 09/20/2022