GEISINGER QUALITY OPTIONS, INC.
(Called the "PPO")

a Pennsylvania for-profit corporation whose home office is
100 North Academy Avenue, Danville, Pennsylvania 17822

COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER POLICY WITH PREVENTIVE SERVICES FOR INDIVIDUAL COVERED PERSONS WITH NO REFERRAL

Identified as the
"Geisinger Choice PPO with No Referral (Non-Group) – "MyChoice Freedom"

REQUIRED OUTLINE OF COVERAGE ("Outline")

A. ***Read Your Policy Carefully.*** This Outline provides a brief description of the important features of your Comprehensive Major Medical Preferred Provider Policy with Preventive Services For Individual Covered Persons with No Referral (the "Policy"), marketed as the "Geisinger Choice PPO with No Referral (Non-Group) – MyChoice Freedom". This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

B. ***Comprehensive Major Medical Expense Coverage.*** Policies of this category are designed to provide insured persons with coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board; miscellaneous hospital services; surgical services; anesthesia services; in-hospital medical services; and out-of-hospital care; subject to any Deductibles, Coinsurance and Copayment provisions or other limitations which may be set forth in the Policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

Coverage is provided for most benefits at Preferred and Non-Preferred benefit levels with Cost Sharing options such as Deductibles, Coinsurance, Copayments and annual Benefit Limits and Lifetime Benefit Maximums. However, benefits for certain services are only available if received from a Preferred Provider. Benefits are subject to medical management review procedures and Precertification processes with penalties and possible loss of benefits for non-compliance. Benefits for Emergency Services and for Covered Services which are not available from a Preferred Provider are provided at the Preferred Provider benefit level, and, in such cases, the Covered Person will not be liable for a greater out-of-pocket expense than if the insured used a Preferred Provider.

C. ***A brief description of the benefits contained in the Policy is as follows:***

1) ***Daily Hospital Room and Board***, which includes a semi-private room and board or a private room, when Medically Necessary, and general nursing care.

2) ***Miscellaneous Hospital Services,*** which includes the use of the following facilities, services and supplies as prescribed by a physician Provider: use of operating room and related facilities; use of intensive care unit or cardiac care unit and services; *radiology, laboratory, and other *diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; *physical therapy, *occupational therapy and *speech therapy; pulmonary rehabilitation therapy; radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma; medical social services and 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. Hospital benefits may be provided at a hospital Provider on either an inpatient or *outpatient basis[*] (see footnote at bottom of this page) or an Ambulatory Surgical Center. Inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the PPO and not determined to be Custodial, Convalescent or Domiciliary Care, except for mastectomy Covered Services as set forth in the Policy.

3) ***Surgical Services,*** which include pre- and post-operative services and special surgical procedures including: transplant services, certain oral surgery, restorative or reconstructive surgery, mastectomy and breast reconstruction surgery.

4) ***Anesthesia Services.*** Coverage is provided for the administration of anesthesia ordered by the attending professional Provider and rendered by a professional Provider other than the surgeon or assistant at surgery. Benefits are provided for the administration of anesthesia for certain oral surgical procedures in an outpatient setting provided that Precertification is obtained from the PPO before the procedure is conducted.

5) ***In-Hospital Medical Services***, which includes inpatient medical care visits, intensive medical care, concurrent care, consultation and routine newborn care.

6) ***Out-of-Hospital Care***, which includes (a) preventive services such as (i) periodic health assessments (including physical examinations, annual gynecological and pelvic examinations, breast exam, chlamydia screening, screening Pap smear, annual screening mammograms for women forty (40) years of age and older and for any Provider recommended mammograms for women under age forty (40), DEXA scan, cholesterol screening and lipid panel); (ii) well-child care; (iii) adult and pediatric immunizations; (iv) diabetes care; (v) colorectal screening; (vi) women's health and well-being preventive services; and (b) diagnostic and other outpatient facility services; (c) physical, occupational and speech therapy services; (d) cardiac rehabilitation services; (e) enteral feeding/food supplements; and (f) diabetes treatment for all types of diabetes.

7) ***Other Benefits,*** which include diagnostic services; injectable drugs; skilled nursing facility services; home health care; transportation services; implanted devices; foot care services; hospice; diabetic medical equipment, supplies, prescription drugs and services; enteral feeding/food supplements; disease and weight management programs; ostomy

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[*] **NOTE**: For **OUTPATIENT** coverage of cardiac rehabilitation, physical therapy, occupational therapy, speech therapy, mental health individual and group therapy, substance abuse services (including Short Term acute outpatient Opioid Detoxification treatment), Computed Axial Tomography (CAT Scans), Magnetic Resonance Imaging (MRI's), Position Emission Tomography (PET Scans), Magnetic Resonance Angiography (MRA's), Echocardiograms, Nuclear cardiology and other nuclear testing; the **Optional Outpatient Benefit Package Rider** must be purchased. The **Optional Outpatient Benefit Package Rider** is not available unless purchased during the initial Policy purchase as set forth on the **Application and Medical Disclosure Questionnaire**.

supplies; urological supplies; voluntary family planning services; pulmonary rehabilitation, rehabilitative devices; dental services and vision services.

8) ***Emergency Services***. Coverage is provided for the treatment of a 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 Covered Person, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy; or (b) serious impairment to bodily functions; or (c) serious dysfunction to any bodily organ or part.

In the event that the Covered Person requires Emergency Services, benefits will be provided at the Preferred Provider services benefit levels. The Covered Person will not be responsible for any difference between the PPO payment and the Provider's charge.

D. ***Benefit Amounts, Durations, Limits, Deductibles, Coinsurance and Copayments for Benefits under the Policy***

1) ***Benefit Period*** is the initial twelve (12) month period of time the Policy is in effect as indicated on the Schedule of Benefits and the subsequent twelve (12) month periods thereafter.

2) ***The Schedule of Benefits***, which is incorporated as a part of the Policy, is a summary of coverage for a Covered Person that identifies the Covered Persons and the Maximum Age for dependent coverage together with the applicable Deductible, Copayments, Copayment Maximums, Coinsurance, Coinsurance Maximums, Benefit Limits and Lifetime Benefit Maximum amounts for Covered Services, and any Riders in force for the Policy. If there is a change in any of the information printed on the Schedule of Benefits (for example, an item has been printed incorrectly or the wrong Schedule of Benefits has been provided), the PPO will issue a new Schedule of Benefits to replace all prior Schedule of Benefits.

3) ***Payment of Benefits.*** Subject to the provisions of the Policy, a Covered Person is responsible for payment of any Cost Sharing amounts due to the Provider after the amounts paid by the PPO hereunder.

4) ***Preferred / Non-Preferred Providers.*** The amount of reimbursement that will be provided by the PPO for Covered Services provided to a Covered Persons is based upon the contractual arrangement between the PPO and the Provider.

i) ***Preferred Provider*** means a physician, medical group, pharmacy, hospital or other provider of health services, licensed, certified or otherwise regulated under any applicable law, that has an agreement with the PPO pursuant to which negotiated rates are established on a Preferred Provider basis for payment of Covered Services to Covered Persons under the Policy.

ii) ***Preferred Provider Fee Schedule Amount*** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Preferred Provider based on the contractual arrangement between the PPO and the Preferred Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Covered Person.

iii) ***Non-Preferred Provider*** includes a physician, medical group, pharmacy, hospital or other provider of health services, licensed, certified or otherwise regulated under any applicable law that does not have an agreement with the PPO.

iv) ***Non-Preferred Provider Fee Schedule Amount*** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Non-Preferred Provider which is generally a percentage of Medicare reimbursement. A Covered Person may obtain information regarding his/her out-of-pocket cost when using a Non-Preferred Provider by contacting the PPO's Customer Service Department at the telephone number on the back of his/her Identification Card.

Generally, Covered Services provided by a Non-Preferred Provider will subject the Covered Person to significant out-of-pocket expenses due to higher Cost Sharing and because such expenses are based on the PPO's Non-Preferred Provider Fee Schedule Amounts, except for Emergency Services or when Covered Services are not available from a Preferred Provider; in such case, the Covered Person will not be liable to the Non-Preferred Provider for any amounts beyond what the Covered Person would have been liable to pay a Preferred Provider.

5) ***Cost Sharing*** means the Deductible, Copayment, Copayment Maximums, Coinsurance and any amounts exceeding the Coinsurance Maximums, Benefit Limits or Lifetime Benefit Maximums that a Covered Person will incur as an expense for Covered Services. Specific Cost Sharing amounts for Covered Services can be found on the Schedule of Benefits and as to Benefit Limits, also in the Policy and any Riders supplementing the Policy.

i) ***Coinsurance*** is a form of Cost Sharing (indicated as a percentage amount on the Schedule of Benefits) which requires the Covered Person to pay a specified portion of the Preferred Provider Fee Schedule Amount or the Non-Preferred Provider Fee Schedule Amount, as set forth on the Schedule of Benefits, after the Deductible has been paid by the Covered Person or Family Unit.

ii) ***Copayment*** is a form of Cost Sharing which requires the Covered Person to pay a fixed amount of money for the cost of Covered Services. Copayment amounts are set forth on the Schedule of Benefits and are due at the time and place such services are received by a Covered Person. Copayment amounts do not accrue toward satisfaction of any Coinsurance Maximum or Deductible amounts. The Copayment charge will never exceed the billed cost of the service. Once the Copayment Maximum has been reached by the Covered Person within a Benefit Period, the Covered Person will not be responsible for any additional Copayments above the Copayment Maximum amount within that Benefit Period.

iii) ***Deductible*** means a specified dollar amount for the cost of Covered Services that must be incurred and paid by a Covered Person or Family Unit before the PPO will assume any liability for all or part of the cost of Covered Services. The Deductible applies to each Covered Person subject to any family Deductible set forth on the Schedule of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers as set forth on the Schedule of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Preferred Providers or Preferred Providers do not accrue toward each other. 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. When a Family Dependent is added to the Policy during the last ninety (90) days of a Benefit Period, if that Family Dependent has not satisfied his/her Deductible prior to the end of the Benefit Period, amounts paid toward satisfaction of that Family Dependent's Deductible during that period shall carry over and accrue toward satisfaction of the Deductible for the next Benefit Period. The only in-network Covered Service subject to a Deductible under the Policy is Dental Services.

iv). ***Benefit Amounts.*** Please note that for services listed with a Copayment below, Coinsurance and Deductible do not apply unless specifically noted otherwise. For services listed below with a Coinsurance, the Deductible applies but there is no Copayment unless specifically noted otherwise. In addition, please note that amounts applied to each Covered Person's single Deductible also apply to the family Deductible (for a Policy with Family Coverage). However, a Covered Person's covered expenses in excess of the single Deductible do not continue to apply to the family Deductible once a Covered Person's single Deductible has been reached.

BENEFIT	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
DEDUCTIBLE	$0 SINGLE $0 FAMILY	$ 4,000 SINGLE $ 8,000 FAMILY
COINSURANCE MAXIMUM	N/A SINGLE N/A FAMILY	$ 10,000 SINGLE $ 20,000 FAMILY
COPAYMENT MAXIMUM	$ 5,000 SINGLE $10,000 FAMILY	N/A
CARDIAC REHABILITATION[2] (Benefit Limit of 36 sessions per Covered Person per Benefit Period)	$20 copayment	40% of Non-Preferred Provider Fee Schedule[1]
CHEMOTHERAPY ADMINISTRATION	$45 Copayment (per course of treatment)	services limited to Preferred Providers
DENTAL SERVICES ($500 limit per benefit period)	$25 SINGLE DEDUCTIBLE $75 FAMILY DEDUCTIBLE	
-Preventive/Palliative Services	20 % Coinsurance	services limited to Preferred Providers
DIABETIC EQUIPMENT, SUPPLIES, DRUGS & SERVICES		
- prescription drug	[Copayment per outpatient prescription drug rider] [or 20% Coinsurance for Covered Persons with no prescription drug rider]	services limited to a Preferred Provider pharmacy
- diabetic foot orthotics	$25 Copayment per billed item	services limited to Preferred Providers
- diabetic medical equipment	$90 Copayment per billed service	services limited to Preferred Providers
- blood glucose test strips (Copayment/Coinsurance per 100 strips)	[Copayment per outpatient prescription drug rider] [or 20% Coinsurance for Covered Persons with no prescription drug rider]	services limited to a Preferred Provider pharmacy

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
- Diabetic training & outpatient education	$20 Copayment	services limited to Preferred Providers
DIABETIC EYE EXAMINATION	$0	services limited to Preferred Providers
DIAGNOSTIC AND OTHER OUTPATIENT SERVICES	$20 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
DIAGNOSTIC IMAGING[2]	$150 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
DURABLE MEDICAL EQUIPMENT[2] ($5,000 Benefit Limit per Covered Person per Benefit Period)	$25 Copayment per billed item	services limited to Preferred Providers
EMERGENCY SERVICES - hospital emergency room (Copayment waived if admitted)	$200 Copayment	$200 Copayment
ENTERAL FEEDING	$300 Copayment	services limited to Preferred Providers
HOME HEALTH CARE		
- Primary Care Physician visits	$20 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
- Specialist visits	$45 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
- other professional visits	$35 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
HOSPICE SERVICES ($10,000 Benefit Limit per Covered Person per lifetime)	$35 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES		
- inpatient Physician services	$0 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
- inpatient hospital facility services	$500 Copayment per day	40% of Non Preferred Provider Fee Schedule[1] (limited to 90 day per Covered Person per Benefit Period)
- outpatient Ambulatory Surgical Center and hospital services	$275 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
IMPLANTED DEVICES		
- drug delivery	$150 Copayment	services limited to Preferred Providers
- contraception	$0 Copayment	services limited to Preferred Providers
- all other implanted devices	$150 Copayment	40% of Non Preferred Provider Fee Schedule[1]

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
INJECTABLES	$75 Copayment	services limited to Preferred Providers
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY		
- post-mastectomy reconstructive surgery		
- inpatient hospital facility services	$500 Copayment per day	services limited to Preferred Providers
- outpatient Ambulatory Surgical Center and hospital services	$275 Copayment	services limited to Preferred Providers
- breast prosthesis		
- surgically implanted	$75 Copayment	services limited to Preferred Providers
- external	$75 Copayment	services limited to Preferred Providers
ORTHOTIC DEVICES[2]	$35 Copayment per billed item	services limited to Preferred Providers
OSTOMY SUPPLIES	$15 Copayment per billed item	services limited to Preferred Providers
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE PROFESSIONAL SERVICES[2] (Benefit Limit of 10 visits per Covered Person per Benefit Period for individual and Group therapy)		
- individual therapy	$25 Copayment per visit	services limited to Preferred Providers
- group therapy	$10 Copayment, per visit	services limited to Preferred Providers
- Short Term Acute Outpatient Opioid Detoxification Treatment (Benefit Limit of 1 uninterrupted 4 month period of treatment per Covered Person per lifetime)	$20 Copayment per visit	services limited to Preferred Providers
PHYSICIAN OFFICE SERVICES		
- Primary Care Physician office visits	$20 Copayment per initial 3 visits per Covered Person per Benefit Period (No coverage for subsequent visits)	40% of Non-Preferred Provider Fee Schedule[1]
- Specialist office visits	$45 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
- Services/Procedures (excludes diagnostic services)	$30 Copayment	40 % of Non-Preferred Provider Fee Schedule[1]
PREVENTIVE SERVICES:	$0 Copayment	services limited to Preferred Providers
- SEE EXHIBIT 4 TO POLICY FOR A LIST OF PREVENTIVE SERVICES	$0 Copayment	services limited to Preferred Providers
- PERIODIC HEALTH ASSESSMENTS		
- Chlamydia screening (limited to women ages 16 – 25)	$0 Copayment	services limited to Preferred Providers
- pap smear	$0 Copayment	services limited to Preferred Providers
- annual mammogram	$0 Copayment	services limited to Preferred Providers
- DEXA scan	$0 Copayment	services limited to Preferred Providers
- cholesterol screening	$0 Copayment	services limited to Preferred Providers
- lipid panel	$0 Copayment	services limited to Preferred Providers

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
- WELL CHILD CARE		
- hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months)	$0 Copayment	services limited to Preferred Providers
- PEDIATRIC IMMUNIZATIONS (not subject to Deductible)	$0 Copayment	services limited to Preferred Providers
- ADULT IMMUNIZATIONS	$0 Copayment	services limited to Preferred Providers
- DIABETES CARE		
- HbAlc test	$0 Copayment	services limited to Preferred Providers
- LDL-C screening	$0 Copayment	services limited to Preferred Providers
- nephropathy screening	$0 Copayment	services limited to Preferred Providers
- COLORECTAL SCREENING		
- fecal occult blood testing	$0 Copayment	services limited to Preferred Providers
- flexible sigmoidoscopy	$0 Copayment	services limited to Preferred Providers
- colonoscopy	$0 Copayment	services limited to Preferred Providers
PULMONARY FUNCTION TESTS	$0 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
PROSTHETIC DEVICES[2] ($5,000 Benefit Limit per Covered Person per Benefit Period)	$150 Copayment	services limited to Preferred Providers
PULMONARY REHABILITATION (Benefit Limit of 36 visits per Covered Person per Benefit Period)	$20 Copayment	40% of Non-Preferred Provider Fee Schedule[1]
RADIATION MEDICINE	$45 Copayment (per course of treatment)	services limited to Preferred Providers
REHABILITATIVE DEVICES	$25 Copayment per billed item	services limited to Preferred Providers
REHABILITATIVE SERVICES[2] (Benefit Limit of 45 dates of service per Covered Person per Benefit Period) - physical therapy - speech therapy - occupational therapy	$45 Copayment per billed service	40% of Non-Preferred Provider Fee Schedule[1]
SELECT INJECTABLE DRUGS (Copayment Maximum of $1500 per Covered Person per Benefit Period)	$250 Copayment (per injection or infusion)	services limited to Preferred Providers
SKILLED NURSING FACILITY SERVICES (Benefit Limit of 60 days of any period of confinement per Covered Person)	$75 Copayment per day	40% of Non-Preferred Provider Fee Schedule[1]
TRANSPLANT PROCEDURES	$5,000 Copayment	services limited to Preferred Providers
TRANSPORTATION SERVICES		
- Emergency Services	$150 Copayment	$150 Copayment
- Scheduled services	$150 Copayment	services limited to Preferred Providers
URGENT CARE		
- Urgent Care Facility Services	$45 Copayment	$45 Copayment
UROLOGICAL SUPPLIES	$30 Copayment	services limited to Preferred Providers

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VISION SERVICES - Eyewear (Benefit Limit of $200 per Covered Person per 2 consecutive Benefit Periods)	$0 Copayment	$0 Copayment
- Refractions (Benefit Limit of 1 visit per Covered Person per Benefit Period)	$0 Copayment	$ 0 Copayment
WELL CHILD OFFICE VISITS (limited to ages 0-21)	$0 Copayment	40% of Non-Preferred Provider Fee Schedule[1]

BENEFITS WITH VISIT BENEFIT LIMITS OR DOLLAR MAXIMUM BENEFIT LIMITS ARE REACHED BASED ON A COMBINATION OF PREFERRED AND NON-PREFERRED PROVIDER SERVICES.

[1] THESE SERVICES MAY SUBJECT THE COVERED PERSON TO SIGNIFICANT OUT-OF-POCKET EXPENSES. FOR INFORMATION ON THE NON-PREFERRED PROVIDER FEE SCHEDULES, CONTACT YOUR CUSTOMER SERVICE TEAM AT THE TELEPHONE NUMBER INDICATED ON THE BACK OF YOUR IDENTIFICATION CARD.

[2] FOR OUTPATIENT COVERAGE OF CARDIAC REHABILITATION, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, MENTAL HEALTH INDIVIDUAL AND GROUP THERAPY, SUBSTANCE ABUSE SERVICES (INCLUDING SHORT TERM ACUTE OUTPATIENT OPIOID DETOXIFICATION TREATMENT), COMPUTED AXIAL TOMOGRAPHY (CAT SCANS), MAGNETIC RESONANCE IMAGING (MRI's), POSITION EMISSION TOMOGRAPHY (PET SCANS), MAGNETIC RESONANCE ANGIOGRAPHY (MRA's), ECHOCARDIOGRAMS, NUCLEAR CARDIOLOGY AND OTHER NUCLEAR TESTING, THE OUTPATIENT SERVICES RIDER MUST BE PURCHASED. THE OUTPATIENT BENEFITS RIDER IS NOT AVAILABLE UNLESS PURCHASED DURING THE INITIAL POLICY PURCHASE AS SET FORTH ON THE APPLICATION AND MEDICAL DISCLOSURE QUESTIONNAIRE.

E. ***Exceptions, Reductions, and Limitations of the Policy.***

1) ***Medically Necessary.*** "Medically Necessary" means that the benefits under the Policy for services received from a Provider will be provided only when and so long as such services are determined by the PPO or its designated agent to be: 1) appropriate for the symptoms and diagnosis and treatment of the Covered Person's condition, illness, disease or injury; and 2) provided for the diagnosis, and the direct care and treatment of the Covered Person's condition, illness, disease or injury; and 3) in accordance with current standards of good medical treatment practiced by the general medical community; and 4) not primarily for the convenience of the Covered Person, or the Covered Person's Provider; and 5) the most appropriate source or level of service that can safely be provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as an inpatient due to the nature of the services rendered or the Covered Person's condition and the Covered Person cannot receive safe or adequate care as an outpatient.

2) ***Medical Management Procedures and Precertification Process.*** Medical Management Procedures include Precertification of non-emergency inpatient admissions and certain designated services and procedures. The purpose of Precertification is to determine Medical Necessity and to encourage and facilitate the use of the most appropriate level of care utilizing objective and evidence-based criteria taking individual circumstances and the local delivery system into account.

3) ***Provider Reimbursement and Covered Person Liability***. The Preferred Provider Fee Schedule Amount is the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Preferred Provider based on the contractual arrangement between the PPO and the Preferred Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Covered Person. Generally, Covered Services provided by a Non-Preferred Provider will subject the Covered Person to significant out-of-pocket expenses due to higher Cost Sharing because such expenses are based on the PPO's Non-Preferred Provider Fee Schedule Amounts (except for outpatient Emergency Services or when Covered Services are not available from a Preferred Provider, such services are paid at the Preferred Provider benefit level).

4) ***For Services and Procedures that Require Precertification the Following Shall Apply***:

i) ***Preferred Provider.*** If the Covered Person chooses to utilize a Preferred Provider for an inpatient hospital admission or for certain designated procedures and services as set forth in the Policy, such ***Preferred Provider*** is responsible for obtaining Precertification from the PPO before the inpatient hospital admission or designated procedure or service occurs. In the event the Preferred Provider fails to obtain Precertification as required, the Covered Person will not be held financially accountable for such services.

ii) ***Non-Preferred Provider.*** If the Covered Person chooses to utilize a Non-Preferred Provider for an inpatient hospital admission or for certain designated procedures and services as set forth in the Policy, the ***Covered Person*** is responsible for (i) informing the Non-Preferred Provider that Precertification is required prior to receiving the procedure or service and (ii) ensuring that Precertification is obtained from the PPO prior to receiving the procedure or service. The Covered Person may do this by contacting the Customer Service Team at the telephone number listed on the back of the Covered Person's Identification Card. Although a Non-Preferred Provider may contact the PPO for Precertification on the Covered Person's behalf, it is ultimately the responsibility of the Covered Person to ensure that Precertification occurs prior to the date of service when the Covered Person chooses a Non-Preferred Provider for the services and procedures set forth in the Policy.

All services and procedures identified in the Policy which are rendered by a Non-Preferred Provider and which REQUIRE Precertification are not Covered Services when Precertification is not obtained.

5) ***Exclusions***. Except as specifically provided in the Policy, the following are **NOT COVERED** by the PPO under the Policy:

5.1 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.

5.2 Any Cost for Covered Services that Exceeds the Lifetime Benefit Maximum. Any cost for Covered Services that exceeds a Lifetime Benefit Maximum is **NOT COVERED.**

5.3 Any Cost for Services Obtained From Non-Preferred Providers that Exceeds the PPO's then Current Non-Preferred Provider Fee Schedule Amount. Any cost for services obtained from Non-Preferred Providers that exceeds the PPO's then current Non-Preferred Provider Fee Schedule Amount is **NOT COVERED**, except with respect to costs associated with Emergency Services as set forth in the Policy or when Covered Services are not available from a Preferred Provider.

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

5.5 Behavioral Services. Any treatment or care related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavioral problems and mental retardation, which extend beyond traditional medical management are **NOT COVERED** except as may be provided under the services set forth in the **Optional Outpatient Benefit Package Rider** if this Rider is purchased by the Covered Person**.**

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

5.7 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 the Policy.

5.8 Cardiac Rehabilitation. Cardiac Rehabilitation is not covered under the Policy unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider.**

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

5.10 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 provided in the Policy Section**, Vision Services.**

5.11 Cosmetic Surgery. Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO is **NOT COVERED**. This exclusion does not apply to Covered Services set forth in certain Policy Sections.

5.12 Custodial, Convalescent or Domiciliary Care. Custodial, Convalescent or Domiciliary Care Services are **NOT COVERED**.

5.13 Dentistry. The PPO does not cover general dental services (defined as operations on teeth or treatment of the teeth and immediately supporting tissues), except for those services listed in the Policy Section, **Dental Services.** Non-covered 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 (except those specifically set forth in Policy), anesthesia, endodontia, prosthodontia, 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.

5.14 Drug Maintenance Programs. Drug maintenance programs for the treatment of outpatient drug Detoxification, dependency or addiction are **NOT COVERED** unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider**.

5.15 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in the Policy, or as may be explicitly provided under the terms of the **No Deductible Outpatient Prescription Drug and Mail Order Rider - with Contraceptives**, if such a Rider is purchased by the Covered Person.

5.16 Drugs and Devices for Purposes of Contraception. Drugs and devices for purposes of contraception are **NOT COVERED** as may be explicitly provided under the terms of the Policy and the **No Deductible Outpatient Prescription Drug and Mail Order Drug Rider – with Contraceptives,** if purchased by the Covered Person**.**

5.17 Durable Medical Equipment. Durable Medical Equipment is not covered under the Policy unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider** or as may be covered under Policy Section, **Rehabilitative Devices.**

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

5.19 Experimental, Investigational or Unproven Services. Experimental, investigational or unproven services are **NOT COVERED**.

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

5.20.1 All non-emergency inpatient hospital admissions; and

5.20.2 the procedures and services set forth in the **Precertification List** of the Policy.

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

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

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

5.24 Government-Sponsored Health Benefits Program. Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are **NOT COVERED**. All required Precertifications must be obtained even when the PPO is the secondary carrier.

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

5.26 Hypnosis. Hypnosis is **NOT COVERED**.

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

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

5.29 Insertion and Removal of Non-Covered Contraceptive Implanted Devices. Any costs, charges or fees associated with the insertion, fitting or removal of an implanted contraceptive device are **NOT COVERED.**

5.30 Insured Obligations. The following amounts are **NOT COVERED**:

a) amounts for any Covered Service which are greater than the PPO's then current Non-Preferred Provider Fee Schedule Amount (except with respect to costs associated with Emergency Services or when Covered Services are not available from a Preferred Provider);

b) amounts for Covered Services which exceed a Lifetime Benefit Maximum set forth on the Schedule of Benefits;

c) amounts for any Covered Service which are applied toward satisfaction of the Copayment, Deductible or Coinsurance amounts; or

d) amounts for any Covered Service which exceed the specific Benefit Limits set forth on the Schedule of Benefits.

5.31 Intoxication or Narcotic Influence. Care, treatment or service for any loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician is **NOT COVERED.**

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

5.33 Maternity Care. Except for complications of pregnancy, maternity care is **NOT COVERED** unless explicitly provided under the terms of the **Maternity Care Rider** if the Covered Person purchases such Rider.

5.34 Mental Health Services, Detoxification and Substance Abuse Rehabilitation Services. The following mental health services, Detoxification and Substance Abuse Rehabilitation Services are **NOT COVERED** under the Policy:

a) mental health inpatient services (except those set forth in the Policy Section **Covered Physician Services in a Hospital or Ambulatory Surgical Center**);

b) partial hospitalization, and electroconvulsive therapy and other outpatient facility services and their related professional services (unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider** which provides outpatient services as set forth in the Rider);

c) inpatient and outpatient Detoxification services, (except for Short Term Acute Outpatient Opioid Detoxification Treatment which is covered if the Covered Person purchases the **Optional Outpatient Benefit Package Rider)**; and

d) Substance Abuse residential, partial hospitalization and other facility services and their related professional services.

NOTE: Outpatient mental health, Detoxification and Substance Abuse Services are covered as set forth in the **Optional Outpatient Benefit Package Rider** if the Covered Person purchases such Supplemental Benefit.

5.35 Missed Appointment Charge. Charges for missed appointments by a Covered Person are **NOT COVERED.**

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

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

5.38 Not Medically Necessary. Covered Services which are not considered Medically Necessary by the PPO are **NOT COVERED** unless, and only if, such services are specifically mandated by applicable state or federal law, or specifically covered under the Policy Section, **Preventive Services.**

5.39 Oral Nutrition Products or Supplements. Oral nutrition products or supplements not used to treat inborn errors of metabolism are **NOT COVERED** including, but not limited to:

a) supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc.;
b) lactose free foods;
c) banked breast milk; and/or
d) standardized or specialized infant formulas.

5.40 Organ Donation to Non-Covered Persons. All costs and services related to a Covered Person donating organ(s) to a non-Covered Person are **NOT COVERED**.

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

5.42 Orthotic Devices. Orthotic Devices are not covered under the Policy unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider** or as may be covered under the Policy Section, **Rehabilitative Devices.**

5.43 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.

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

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

5.46 Prescription Drug, Device or Equipment Use by a Non-Covered Person. Use by anyone other than the Covered Person of a prescription drug, device or equipment provided to a Covered Person according to the terms and conditions set forth in the Policy Section, **Covered Services**, or the **No Deductible Outpatient Prescription Drug and Mail Order Drug Rider – with Contraceptives** and the **Optional Outpatient Benefit Package Rider** (if such Riders are purchased with the Policy), is **NOT COVERED**.

5.47 Prescription Bandages and Wound Dressings. Outpatient prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in the Policy Section, **Ostomy Supplies**.

5.48 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.

5.49 Prosthetic Devices. Prosthetic Devices are not covered under the Policy unless the Covered Person purchases the **Optional Outpatient Benefit Package Rider** or as may be covered under the Policy Section, **Rehabilitative Devices.**

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

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

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

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

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

5.55 Services Provided by a Covered Person'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 Covered Person are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.

5.56 Services Provided in Conjunction with a Non-Covered Service. Any service, which would otherwise be a Covered Service under the Policy, 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 Covered Person's receipt of a non-Covered Service.

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

5.58 Surgery for Treatment of Morbid Obesity. Surgical treatment of morbid obesity is **NOT COVERED.**

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

5.60 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.

5.61 Weight Control. Weight reduction programs for non-morbid obesity are **NOT COVERED** unless as provided for in the Policy Section, **Weight Management Program** or as set forth in the Policy Exhibit, **Preventive Services**.

5.62 THE FOLLOWING SERVICES ARE NOT COVERED WHEN OBTAINED FROM NON-PREFERRED PROVIDERS:

5.62.1 **Dental Services.** Dental Services obtained from Non-Preferred Providers are **NOT COVERED.**

5.62.2 **Diabetic Medical Equipment, Blood Glucose Monitors, Diabetic Foot Orthotics, Insulin and Oral Pharmacological Agents for Controlling Blood Sugar, Disposable Syringes, Blood Glucose Monitor Supplies (Lancets and Blood Glucose Test Strips) and Outpatient Training and Education.** Diabetic medical equipment, blood glucose monitors, foot orthotics, insulin and oral pharmacological agents for controlling blood sugar, disposable syringes, blood glucose monitor supplies (lancets and blood glucose test strips) and outpatient training and education obtained from a Non-Preferred Provider are **NOT COVERED**.

5.62.3 **Enteral Feedings/Food Supplements.** Enteral feedings/food supplements obtained from Non-Preferred Providers are **NOT COVERED.**

5.62.4 **Foot Care Services**. Foot Care services obtained from Non-Preferred Providers are **NOT COVERED**.

5.62.5 **Genetic Counseling and Testing.** Genetic counseling and testing obtained from Non-Preferred Providers are **NOT COVERED.**

5.62.6 **Implanted Devices.** Implanted devices for the purpose of drug delivery obtained from Non-Preferred Providers are **NOT COVERED.**

5.62.7 **Injectables.** Injectables obtained from Non-Preferred Providers are **NOT COVERED**.

5.62.8 **Organ, Bone Marrow, Stem Cell or Corneal Transplants, Evaluation and Related Services.** Organ, bone marrow, stem cell or cornel transplants, evaluation and related services obtained from Non-Preferred Providers are **NOT COVERED**.

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

5.62.10 **Pain Management.** Pain management services obtained from Non-Preferred Providers are **NOT COVERED**.

5.62.11 **Post-Mastectomy Reconstructive Surgery and Breast Prostheses.** Post-mastectomy reconstructive surgery and breast prostheses services obtained from Non-Preferred Providers are **NOT COVERED**.

5.62.12 **Preventive Services.** Preventive services obtained from Non-Preferred Providers are **NOT COVERED.**

5.62.13 **Refractions.** Refractions as set forth in the Policy are **NOT COVERED** when obtained from a Non-Preferred Provider.

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

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

5.63. THE FOLLOWING EXCLUSIONS APPLY TO SECTION 3.29, VISION SERVICES. THE FOLLOWING ARE **NOT COVERED** UNDER THE POLICY.

5.63.1 **Repairs**. Repairs to Prescription Eyewear are **NOT COVERED**.

5.63.2 **Shipping Charges.** Any shipping charges associated with the purchase or orders of Prescription Eyewear are **NOT COVERED**.

5.63.3 **Warranties.** Supplemental warranties for Prescription Eyewear are **NOT COVERED**.

5.63.4 **Cleaning Accessories.** Cleaning kits and other cleaning accessories or solutions for Prescription Eyewear are **NOT COVERED**.

5.63.5. **Vision Procedures**. Laser vision corrective surgery and other medical and/ or surgical procedures related to the eye are **NOT COVERED**.

5.63.6 **Orthoptic and Vision Training**. Orthoptic and vision training are **NOT COVERED**.

5.63.7 **Eyeglass and Contact Accessories.** Eyeglass and contact accessories, which may include but are not limited to, carrying cases, holders, sunglass clip-lenses and repair kits, are **NOT COVERED.**

5.63.8 **Non-Prescription Eyewear.** Non-Prescription Eyewear, including but not limited to: eyeglasses, frames, lenses, sunglasses, safety glasses, magnification aids and contact lenses is **NOT COVERED**.

5.63.9 **Fittings**. Fittings for eyeglasses, lenses and contact lenses are **NOT COVERED**.

5.63.10 Any costs or fees for Prescription Eyewear purchases which exceed the $200 allowance per two (2) consecutive Benefit Periods are **NOT COVERED** by the PPO and will be the responsibility of the Covered Person.

5.63.11 Any costs or fees indicated on a single receipt submitted for Prescription Eyewear which exceed the $200 allowance are **NOT COVERED** and will be the responsibility of the Covered Person.

5.63.12 Claims for Prescription Eyewear that are submitted to the PPO later than one (1) year from the date of purchase are **NOT COVERED**.

5.63.13 **Additional Ophthalmological Services**. Additional ophthalmological services provided during the same visit as the refractive examination, unless such services are provided for in the Policy are **NOT COVERED**.

5.63.14 **Non-Preferred Providers**. Refraction services that are obtained from Non-Preferred Providers are **NOT COVERED.**

F. ***Terms and Conditions of the Renewability of the Policy.***

1) ***Guaranteed Renewable.*** The Policy is guaranteed renewable and shall renew monthly upon payment of the required premium. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under the Policy. Premium will change only as described in F.3 below.

2) ***Termination.*** Subject to the right of the PPO to terminate coverage, and to any amendment permitted under applicable law, the Policy will remain in effect continually until terminated by the Policyholder or the PPO in accordance with the following:

i) The Policy may be terminated by the Policyholder by giving thirty (30) days written notice to the PPO.

ii) The Policy is guaranteed renewable and cannot be terminated by the PPO except in the following instances:

a) if payment of the appropriate premium is not made when due or during the grace period;

b) if a Covered Person in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (i.e., misuse of the Identification Card). However, the PPO will not terminate the Policy because of a Covered Person's Medically Necessary utilization of services covered under the Policy;

c) upon one hundred eighty (180) days notice to the Policyholder when the PPO discontinues all individual coverage within the Service Area; and

d) in the event the Policyholder no longer lives in the Service Area.

e) In the event that a Family Dependent becomes ineligible because:

i. a child ceases to meet any of the requirements for Family Dependent coverage set forth in Section 6, **Eligibility**, of the Policy; or

ii. a spouse becomes divorced from the Policyholder;

such individual may exercise his/her right to convert to a separate individual policy, as set forth in the **Continued Eligibility and Conversion**. Section of the Policy,

In the event of the death of the Policyholder, the spouse shall become the Policyholder and the Policy shall continue in full force and effect.

3) ***Modification/Premium Subject to Change on a Class Basis.*** Subject to the approval of the Pennsylvania Insurance Department, the PPO may adjust the premium rate. Any change in the premium shall become applicable for the Policyholder only upon renewal of the Policy at the anniversary date of the Policy (unless a Covered Person's material misrepresentation or omission in the Application and Medical Disclosure Questionnaire would have resulted in a different initial premium, in which case the PPO may adjust the premium to the appropriate level. The PPO's right to adjust premiums in this manner is subject to the **Time Limits on Certain Defenses** provision of the Policy). Premiums will be charged to the Policyholder based upon the attained age of the oldest Covered Person at the time the application for coverage is approved, and the Policy renewal premium will be based on the attained age at the time of renewal.

Healthy Rewards

Earn money for fitness activities

Need motivation to exercise? Already work out regularly? Healthy Rewards is a reimbursement program that helps members pay for fitness activities. Be rewarded for making good choices!

How does it work?

- Reimbursement up to $100/single and $200/family
- Members (policyholder only) must complete an online Health Risk Assessment (HRA) to be eligible
- Activities considered include:
  - Fitness center memberships
  - Exercise classes
  - Race fees
  - School athletic fees
  - Swimming lessons
  - Gymnastics
  - Sports camps
  - Sports fees
  - Karate and more!

How do I get it?

As of April 1, 2012, Healthy Rewards is effective immediately for any new groups and individuals who enroll with us. Anyone currently enrolled with us through an employer or on your own is eligible upon your renewal.

See reverse side for instructions on the HRA!

Visit **thehealthplan.com** for more information.

"Like" us today!
facebook.com/GeisingerHealthPlan

GEISINGER HEALTH PLAN®

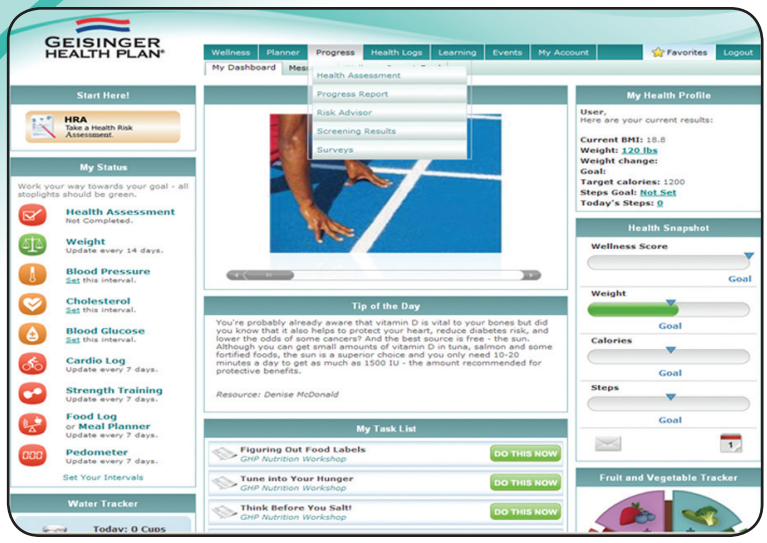
GEISINGER CHOICE®

*Healthy Rewards is not available for Geisinger Gold, Geisinger Health Options or GHP Kids members. Reimbursement is subject to approval by Geisinger Health Plan and Geisinger Choice. The policyholder is the only member required to take an HRA, but each member must fill out the Health Rewards Reimbursement Form.

HPM50 ad Healthy Rewards Wellness Online flyer Rev. 1/2013

Wellness Online

Interactive tools to keep you on track



One of the first steps toward a healthier you is getting a snapshot of your current health. Geisinger Health Plan's* Wellness Online can help you do that! Our Health Risk Assessment (HRA) will give you a health score, risk for specific conditions and includes recommendations on ways you can improve your health. **You can access and update your HRA at anytime.** Wellness Online also includes other beneficial tools you can use to keep track of your eating and exercise habits. Our goal is to keep you and your family healthy. Wellness Online can help.

What will you need? It's a good idea to have your health history available, like medical and lifestyle information, to get the best results. And remember, there is no cost to you.

Contact us today by calling the phone number on the back of your member ID card!

GEISINGER HEALTH PLAN® GEISINGER CHOICE®

*Geisinger Choice is a service offered through Geisinger Quality Options, Inc., an affiliate of Geisinger Health Plan.

To access Wellness Online and the HRA:

- Visit thehealthplan.com**
- Log in as a member (registration required)
- Once logged in, click on the "Health and Wellness" section on the left navigation bar and choose "Wellness Online"
- You will be required to accept the privacy terms to continue. You will then be redirected to our Wellness Online page
- To access or update your HRA, select the "Progress" tab then "Health Assessment"

Other Wellness Online benefits:

- Track and analyze your personal health, nutrition and fitness data through "My Dashboard" under the "Wellness" tab
- Enroll in wellness workshops on various topics including weight, stress, diabetes, tobacco cessation and more! You can complete these at your own pace and manage them through the "Planner" tab
- Access to an online meal planner based on your own dietary and caloric needs. Search for recipes, build your own shopping list and more (under the "Planner" tab)
- Use our health logs to track and graph your blood pressure, blood glucose, cholesterol and heart rate

Earn money through our Healthy Rewards program. Turn this page over to learn more!

If you are part of an employer wellness program with access to Wellness Online, but not a member, log in at **wellness.thehealthplan.com. Members log in at thehealthplan.com. If you are unable to access this information, please contact your employer or our wellness team at (866) 415-7138.