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 QUALIFIED HIGH DEDUCTIBLE PREFERRED PROVIDER POLICY WITH PREVENTIVE SERVICES FOR INDIVIDUAL COVERED PERSONS WITH NO REFERRAL

Identified as the
"Geisinger Choice PPO with No Referral (Non-Group) – High Deductible Health Plan"

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 Qualified High Deductible 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) – High Deductible Health Plan." 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.*** This Policy, marketed as the "Geisinger Choice PPO with No Referral (Non-Group) – High Deductible Health Plan", sets forth a comprehensive major medical program of inpatient and outpatient facility and professional Provider benefits, most of which are provided at network and out-of-network benefit levels. This program is available to individuals who wish to purchase a qualified High Deductible Health Plan for use with a Health Savings Account as defined by the Internal Revenue Service. This program includes either an individual Deductible or a family Deductible, Coinsurance, and annual and Lifetime Benefit Maximums. Benefits are subject to the medical management procedures and Precertification process provisions with possible loss of benefits for non-compliance. Benefits for certain services are only available if received from a network Provider. Network benefits that utilize Preferred Providers are usually provided at a higher benefit level than out-of-network services. Except for a newborn child of a Covered Person, enrollment is subject to medical underwriting. This Policy is non-participating in any divisible surplus of premium.

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 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 and 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 include inpatient medical care visits, intensive medical care, concurrent care, and 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) pediatric and adult immunizations; (iv) diabetes care and (v) colorectal screening; (b) diagnostic and other outpatient facility services; (c) physical, occupational and speech therapy services; (d) cardiac rehabilitation services; (e) outpatient professional mental health and Substance Abuse services (including short term acute outpatient opioid detoxification treatment); (f) enteral feeding/food supplements; and (g) diabetes treatment for all types of diabetes.

7) ***Prosthetic and Orthotic Devices and Durable Medical Equipment,*** which includes Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.

8) ***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; disease and weight management programs; ostomy supplies, urological supplies and voluntary family planning services.

9) ***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; (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 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, Coinsurance, Deductible Coinsurance and Copayment Maximum (DCC Maximum) and Lifetime Benefit Maximum amounts for Covered Services. Certain benefits have specific Benefit Limits such as a maximum dollar amount covered per Benefit Period or a maximum number of Covered Services covered in a Benefit Period. These Benefit Limits are also listed on the Schedule of Benefits. If there is a change in any of the information printed on the Schedule of Benefits (for example, an item has been printed incorrectly or the wrong Schedule of Benefits has been provided), the PPO will issue a new Schedule of Benefits to replace all prior Schedules of Benefits.

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 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) ***The 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, Coinsurance and any amounts exceeding the DCC 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. Coinsurance amounts accrue toward satisfaction of the DCC Maximum amounts.

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 after the Deductible has been met. 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 accrue toward satisfaction of any DCC Maximum amounts. Once the DCC Maximum has been met, no further Copayment amounts are required to be paid by the Covered Person.

iii) ***Deductible*** means a specified dollar amount as set forth on the Schedule of Benefits for the cost of Covered Services that must be paid under the Policy before the PPO will assume any liability for all or part of the cost of Covered Services. 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. Deductible amounts accrue towards satisfaction of any DCC Maximum amounts. 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.

iv) ***Benefit Amounts.*** Please note that with this High Deductible Health Plan, all benefits except for Preventive Services are subject to a Deductible. For services listed below with a Coinsurance, the Deductible applies but there is no Copayment unless specifically noted otherwise. All Coinsurance, Deductible and Copayment amounts paid under the

Policy accrue towards the DCC Maximum amount indicated on the Schedule of Benefits.

BENEFIT	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
DEDUCTIBLE	[see chart in 5 (v) below] SINGLE [see chart in 5 (v) below] FAMILY	[see chart in 5 (v) below] SINGLE [see chart in 5 (v) below] FAMILY
DEDUCTIBLE, COINSURANCE and COPAYMENT INSURANCE MAXIMUM (does not include Select Injectable Drugs; see separate DCC Maximum for include Select Injectable Drugs below)	[see chart in 5 (v) below] SINGLE [see chart in 5 (v) below] FAMILY	[see chart in 5 (v) below] SINGLE [see chart in 5 (v) below] FAMILY
CARDIAC REHABILITATION (b) (Benefit Limit of 36 sessions per Covered Person per Benefit Period)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
DIABETIC EQUIPMENT, SUPPLIES, DRUGS		
- prescription drug (c)	Copayment per prescription drug benefit	svcs limited to a Participating Pharmacy
- diabetic foot orthotics (c)	10% Coinsurance	svcs limited to Preferred Providers
- diabetic medical equipment (c)	10% Coinsurance	svcs limited to Preferred Providers
- blood glucose test strips (c) (Copayment per 100 strips)	Copayment per prescription drug benefit	svcs limited to a participating pharmacy
DIABETIC EYE EXAMINATION (a)	10% Coinsurance	svcs limited to Preferred Providers
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
DURABLE MEDICAL EQUIPMENT (c) ($2,500 Benefit Limit per Covered Person per Benefit Period)	10% Coinsurance	svcs limited to Preferred Providers
EMERGENCY SERVICES (b) - hospital emergency room (Copayment waived if admitted)	$150 Copayment	$150 Copayment
ENTERAL FEEDING (c)	10% Coinsurance	svcs limited to Preferred Providers
HOME HEALTH CARE		
- Primary Care Physician visits (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- Specialist visits (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- other professional visits (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
HOSPICE SERVICES (b) ($10,000 Benefit Limit per Covered Person per lifetime)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES		
- inpatient Physician Services (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- inpatient hospital facility services (b)	10% Coinsurance	30%; of Non-Preferred Provider Fee Schedule * (limited to 90 days per Covered Person per Benefit Period)

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
- outpatient Ambulatory Surgical Center and hospital services (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
IMPLANTED DEVICES		
- drug delivery, contraception (c)	10% Coinsurance	svcs limited to Preferred Providers
- all other implanted devices (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
INJECTABLES (c)	10% Coinsurance	svcs limited to Preferred Providers
MASTECTOMY AND BREAST CANCER RECONSTRUCTIVE SURGERY		
- post-mastectomy reconstructive surgery (c)	10% Coinsurance	svcs limited to Preferred Providers
- breast prosthesis (c)	10% Coinsurance	svcs limited to Preferred Providers
- surgically implanted	10% Coinsurance	svcs limited to Preferred Providers
- external	10% Coinsurance	svcs limited to Preferred Providers
MATERNITY CARE		
- inpatient facility services (c)	10% coinsurance	svcs limited to Preferred Providers
- inpatient specialist services (c)	10% Coinsurance	svcs limited to Preferred Providers
- inpatient primary care services (c)	10% Coinsurance	svcs limited to Preferred Providers
- maternity home health visit for early discharge (c)	$0 Coinsurance/Copayment	svcs limited to Preferred Providers
- maternity office visits (c)	10% Coinsurance	svcs limited to Preferred Providers
MRI/CAT SCAN/PET SCAN/ MRA NUCLEAR CARDIOLOGY (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
ORTHOTIC DEVICES (c)	50% Coinsurance	svcs limited to Preferred Providers
OSTOMY SUPPLIES (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE PROFESSIONAL SVCS (Benefit Limit of 10 visits per Covered Person per Benefit Period for individual and group therapy)		
- individual therapy (c)	10% Coinsurance	svcs limited to Preferred Providers
- group therapy (c)	10% Coinsurance	svcs limited to Preferred Providers
- Short Term Acute Outpatient Opioid Detoxification Treatment (c) (Benefit Limit of 1 uninterrupted 4 month period of treatment per Covered Person per lifetime)	10% Coinsurance	svcs limited to Preferred Providers
PHYSICIAN OFFICE SERVICES		
- Primary Care Physician office visits (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- Specialist office visits (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- Diagnostic Services/Procedures (b)	10% Coinsurance	30% of Non-Preferred Provider Fee

BENEFIT	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
PRESCRIPTION DRUG (c)	$5 Copayment 1st tier, $35 Copayment 2nd tier $55 Copayment 3rd tier	svcs limited to a Participating Pharmacy
- Human growth hormone (c)	20% Coinsurance	svcs limited to a Participating Pharmacy
- Mail Order Drug (c)	2.5x prescription drug Copayment or Coinsurance	svcs limited to a Participating Pharmacy
PREVENTIVE SERVICES: (a)	$0 Copayment	svcs limited to Preferred Providers
- SEE EXHIBIT 3 TO POLICY FOR A LIST OF PREVENTIVE SERVICES	$0 Copayment	svcs limited to Preferred Providers
- PERIODIC HEALTH ASSESSMENTS		
- Chlamydia screening (limited to women ages 16 – 25)	$0 Copayment	svcs limited to Preferred Providers
- Pap smear	$0 Copayment	svcs limited to Preferred Providers
- annual mammogram	$0 Copayment	svcs limited to Preferred Providers
- DEXA scan	$0 Copayment	svcs limited to Preferred Providers
- cholesterol screening	$0 Copayment	svcs limited to Preferred Providers
- lipid panel	$0 Copayment	svcs limited to Preferred Providers
- WELL CHILD CARE		
- hemoglobin and hematocrit (Benefit Limit of one service under the age of 24 months)	$0 Copayment	svcs limited to Preferred Providers
- PEDIATRIC IMMUNIZATIONS	$0 Copayment	svcs limited to Preferred Providers
- ADULT IMMUNIZATIONS	$0 Copayment	svcs limited to Preferred Providers
- DIABETES CARE		
- HbAlc test	$0 Copayment	svcs limited to Preferred Providers
- LDL-C screening	$0 Copayment	svcs limited to Preferred Providers
- nephropathy screening	$0 Copayment	svcs limited to Preferred Providers
- COLORECTAL SCREENING		
- fecal occult blood testing	$0 Copayment	svcs limited to Preferred Providers
- flexible sigmoidoscopy (limited to age 50 and over)	$0 Copayment	svcs limited to Preferred Providers
- colonoscopy (limited to age 50 and over)	$0 Copayment	svcs limited to Preferred Providers
- Routine physicals	$0 Copayment	svcs limited to Preferred Providers
- Home blood glucose monitor	$0 Copayment	svcs limited to Preferred Providers
PROSTHETIC DEVICES (c) ($5,000 Benefit Limit per Covered Person per Benefit Period)	10% Coinsurance	svcs limited to Preferred Providers
PULMONARY REHABILITATION (b) (Benefit Limit of 36 visits per Covered Person per Benefit Period)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule*
REHABILITATIVE SERVICES (b) (Benefit Limit of 45 days of service per Covered Person per Benefit Period) - Physical therapy - Speech therapy - Occupational therapy	10% Coinsurance per date of service	30% of Non-Preferred Provider Fee Schedule *
SELECT INJECTABLE DRUGS (c) (per injection or infusion not to exceed $1500 DCC Maximum per Covered Person per Benefit Period)	10% Coinsurance	svcs limited to Preferred Providers
SKILLED NURSING FACILITY SERVICES (b) (Benefit Limit of 60 days of any period of confinement per Covered Person)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
TRANSPLANT SERVICES		
- Human Leukocyte Antigen (HLA) Typing (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule *
- Transplant surgery service (c)	10% Coinsurance	svcs limited to Preferred Providers
TRANSPORTATION SERVICES		
- Emergency Services (b)	$150 Copayment	$150 Copayment
- Scheduled Services (c)	$150 Copayment	svcs limited to Preferred Providers
URGENT CARE (b)		
- Urgent Care Facility Services	10% Coinsurance	10% Coinsurance
UROLOGICAL SUPPLIES (b)	10% Coinsurance	30% of Non-Preferred Provider Fee Schedule*
WELL CHILD OFFICE VISITS (b) (limited to ages 0-21)	$0 Copayment	30% of Non-Preferred Provider Fee Schedule*

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

PLEASE NOTE THE (a), (b) OR (c) INDICATED NEXT TO EACH BENEFIT LISTED ABOVE FOR AN EXPLAINATION AS TO THE APPLICABLE COST SHARING FOR THAT BENEFIT.

(a) DEDUCTIBLE DOES NOT APPLY. SERVICE IS LIMITED TO PREFERRED PROVIDERS.

(b) DEDUCTIBLE APPLIES TO BOTH PREFERRED AND NON-PREFERRED PROVIDERS. DEDUCTIBLE MUST BE SATISFIED BEFORE COPAYMENT OR COINSURANCE APPLIES.

(c) DEDUCTIBLE APPLIES TO PREFERRED PROVIDERS ONLY. DEDUCTIBLE MUST BE SATISFIED BEFORE COPAYMENT OR COINSURANCE APPLIES. SERVICE IS LIMITED TO PREFERRED PROVIDERS.

MAXIMUM AGE FOR DEPENDENT CHILDREN: Dependent up to age 26

v) The "Schedule of Benefits Cost Sharing Chart" below summarizes the above bracketed Cost Sharing for Plans 1-3 of the "Geisinger Choice PPO with No Referral (Non-Group) – High Deductible Health Plan". For a detailed explanation of the Cost Sharing terms such as "Deductible", "Coinsurance" etc., indicated in the Chart, please refer to Section D (5) of this Outline of Coverage. To determine the Cost Sharing for a specific Covered Service, please refer to the above Schedule of Benefits.

SCHEDULE OF BENEFITS COST SHARING CHART

PLAN		DEDUCTIBLE	DEDUCTIBLE, COINSURANCE & COPAYMENT MAXIMUM
1	Preferred Provider	$1,400 Single	$2,200 Single
		$2,800 Family	$4,400 Family
	Non-Preferred Provider	$2,500 Single	$5,000 Single
		$5,000 Family	$10,000 Family
2	Preferred Provider	$2,600 Single	$3,800 Single
		$5,200 Family	$7,600 Family
	Non-Preferred Provider	$3,800 Single	$6,000 Single
		$7,600 Family	$12,000 Family
3	Preferred Provider	$2,850 Single	$5,000 Single
		$5,700 Family	$10,000 Family
	Non-Preferred Provider	$5,000 Single	$10,000 Single
		$10,000 Family	$20,000 Family

The above chart is meant to provide an example of the Cost Sharing differences for Plans 1-3 of the Geisinger Choice PPO with No-Referral (Non-Group) – High Deductible Health Plan and the Cost Sharing amounts indicated in the chart are not intended to replace or supplement the Schedule of Benefits.

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

1) ***Pre-Existing Condition Exclusion Period***. "Pre-Existing Condition" means any condition for which medical advice, care, treatment, or diagnosis has been recommended or received from a Provider within a five (5) year period immediately preceding the effective date of the coverage of the Covered Person. During an exclusion period of twelve (12) months following the Covered Person Effective Date, no benefits are provided under the Policy for care related to Pre-Existing Condition(s). The Pre-Existing Condition exclusion period will **not** be imposed on the following Covered Persons up to age 19: 1) the Policyholder; 2) the Policyholder's spouse; and/or 3) the Policyholder's child (or a Policyholder's spouses child, if applicable), whether natural born, adopted or placed for adoption.

2) ***Medically Necessary***. "Medically Necessary" means that the benefits under this 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.

3) ***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 encourage and facilitate use of the most appropriate level of care for Medically Necessary services utilizing industry accepted criteria for severity of illness and intensity of service.

4) ***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 and because such expenses are based on the PPO's Non-Preferred Provider Fee Schedule Amounts (except for outpatient Emergency Services or when Covered Services are not available from a Preferred Provider).

5) ***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.

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

6.1 Acupuncture. Acupuncture is **NOT COVERED.**

6.2 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.**

6.3 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 or when Covered Services are not available from a Preferred Provider.

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

6.5 Behavioral Services. Any treatment or care related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavioral problems and mental retardation which extend beyond traditional medical management are **NOT COVERED**, except as provided in the Policy.

6.6 Biofeedback. Biofeedback is **NOT COVERED.**

6.7 Blood or Other Body Tissue and Fluids, Including Storage. Blood and its components or any artificially created blood products are **NOT**

COVERED. Storage of blood, including autologous and cord blood, other body tissue and fluids is **NOT COVERED.**

6.8 Breast Surgery. Surgery for male or female breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy.

6.9 Charges Covered under Certain Acts of 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.

6.10 Corrective Devices. The purchase, fitting, or adjustment of corrective devices including, but not limited to, eyeglasses, contact lenses, and hearing aids are **NOT COVERED**.

6.11 Cosmetic Surgery. Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO is **NOT COVERED**. This exclusion does not apply to a) mastectomy reconstructive surgery and reconstruction of the other breast to produce a symmetrical appearance pursuant to a mastectomy; b) restorative or reconstructive surgery to correct a medically diagnosed congenital defect or birth abnormality and c) covered surgery performed to reasonably restore a Covered Person to the approximate physical condition they were in prior to a defect resulting from a covered sickness, accidental injury or incidental to surgery.

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

6.13 Dentistry. The PPO does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include, but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the PPO will cover expenses related to the emergency treatment of sound natural teeth as set forth in the Policy (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth).

6.14 Drug Maintenance Programs. Drug maintenance programs for the treatment of outpatient drug Detoxification, dependency or addiction are **NOT COVERED**. This drug maintenance program exclusion includes but is not necessarily limited to the outpatient use of the drugs Suboxone™ and Subutex™ or their generic equivalents in an outpatient drug maintenance program except as set forth in the Policy.

6.15 **Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in the Policy.

6.16 **Drugs and Devices for Purposes of Contraception.** Prescription or non-prescription drugs and devices (including condoms) for purposes of contraception are **NOT COVERED** except as provided in this Policy.

6.17 **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.

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

6.19 **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:

6.19.1 All non-emergency inpatient hospital admissions; and

6.19.2 the procedures and services set forth in the Policy which require Precertification.

6.20 **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**.

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

6.22 **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**.

6.23 **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.

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

6.25 **Hypnosis.** Hypnosis is **NOT COVERED**.

6.26 **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**.

6.27 **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**.

6.28 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, when such device is not covered under the terms of this Policy, are **NOT COVERED.**

6.29 Insured Obligations. The following amounts are NOT COVERED:

(i) amounts for any Covered Service provided by a Non-Preferred Provider 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);

(ii) amounts for Covered Services that exceed the Lifetime Benefit Maximum set forth on the Schedule of Benefits;

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

(iv) amounts for any Covered Service which exceed the specific benefit limits set forth on the Schedule of Benefits.

6.30 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**.

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

6.32 Mental Health Services, Detoxification and Substance Abuse Rehabilitation Services. The following Mental Health Services, Detoxification and Substance Abuse Rehabilitation Services are **NOT COVERED** under this PPO:

(a) mental health inpatient services (except those set forth in the Policy);

(b) partial hospitalization, and electroconvulsive therapy and other outpatient facility services and their related professional services other than those specifically provided in the Policy;

(c) inpatient and outpatient Detoxification services (except for Short Term acute outpatient Opioid Detoxification treatment as set forth in the Policy); and

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

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

6.34 **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.**

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

6.36 **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 as Preventive Services.

6.37 **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**.

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

6.39 **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.

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

6.41 **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 Section 3, the **Covered Services** section of the Policy, is not covered.

6.42 **Prescription Bandages and Wound Dressings**. Outpatient prescription bandages and other wound dressing products are not covered except as may be provided in the Policy.

6.43 **Private Duty Nursing.** Hourly nursing care on a private duty basis is **NOT COVERED**.

6.44 **Refraction Examinations.** Examinations to determine the refractive error of the eye are **NOT COVERED**.

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

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

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

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

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

6.50 **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**.

6.51 **Services Provided in Conjunction with a Non-Covered Service**. Any service, which would otherwise be a Covered Service under this 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.

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

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

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

6.55 **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.

6.56 **Weight Control.** Weight reduction programs for non-morbid obesity are **NOT COVERED** unless as provided for in the Policy.

6.57 **THE FOLLOWING ARE NOT COVERED UNDER OUTPATIENT PRESCRIPTION DRUGS AS SET FORTH IN SECTION 3.19 OF THE POLICY**:

6.57.1 **Allergy Injections** are **NOT COVERED.**

6.57.2 **Any Brand Name Drug with any Variation or Degree of the Following FDA-Approved Indications**, regardless of prescribed use by a Provider or intended use by a Covered Person is **NOT COVERED**:

i. Anxiety Disorders
ii. Attention Deficit/Hyperactivity Disorders
iii. Bipolar Disorders
iv. Depression
v. Eating Disorders (including, but not limited to, Bulimia and Anorexia)

vi. Obsessive Compulsive Disorders
vii. Panic Disorders
viii. Post Traumatic Stress Disorders
ix. Pre-menstrual Dysphonic Disorders
x. Psychotic Disorders
xi. Schizophrenia
xii. Substance Abuse Disorders (including, but not limited to, alcohol and drug abuse)

6.57.3 **Cosmetic Indications.** Prescription drugs prescribed for cosmetic indications are **NOT COVERED**, 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).

6.57.4 **Devices**. The following non-contraceptive and contraceptive devices are **NOT COVERED:**

i) **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 **Diabetic Medical Equipment** Section of the Policy); diagnostic devices and supplies.

ii) **Contraceptive Devices.** Prescription or non-prescription contraceptive devices including but not limited to condoms and implantable devices for the purpose of releasing contraceptive drugs.

6.57.5 Dietary supplements, vitamins (except prescription prenatal), fluoride supplements/rinses, anabolic steroids, blood plasma products or irrigation solutions are **NOT COVERED**.

6.57.6 **Drugs Available without a Prescription**. Drugs written as Prescription Drugs which are available without a prescription in the same strength are **NOT COVERED**.

6.57.7 **Drugs which are not Prescription Drugs** as defined in the Policy are **NOT COVERED**.

6.57.8 **Erectile Dysfunction Medications** are **NOT COVERED.**

6.57.9 **Experimental Drugs**, including those labeled "Caution-limited by Federal law to Investigational Use," non-FDA approved drugs, FDA approved drugs for investigational indications or for non-FDA approved uses or at investigational doses and drugs found by the FDA to be ineffective are **NOT COVERED**.

6.57.10 **Extemporaneous Dosage Forms of Natural Estrogen or Progesterone**, including but not limited to oral capsules, suppositories and troches are **NOT COVERED**.

6.57.11 **Immunizations** are **NOT COVERED** except those as set forth in the Policy.

6.57.12 **Non-Drug Formulary Prescription Drugs**. Prescription Drugs which are not included on the Drug Formulary unless authorized in advance by the PPO are **NOT COVERED.**

6.57.13 **Non-Formulary Drugs**, restricted drugs or drugs requiring prior authorization by the PPO which have been obtained prior to receiving such authorization are **NOT COVERED**.

6.57.14 **Non-Participating Pharmacies**. Outpatient prescription drugs obtained from Non-Participating Pharmacies are **NOT COVERED**.

6.57.15 **Not Medically Necessary.** Drugs that are not Medically Necessary as determined by the PPO are **NOT COVERED.**

6.57.16 **Over-the-Counter Drugs and Other Items Available without a Prescription**, whether provided with or without a prescription, are **NOT COVERED**, except as set forth in the Policy.

6.57.17 **Prescription Bandages and other Wound Dressing Products** are **NOT COVERED.**

6.57.18 **Prescription Replacements** for lost, destroyed or stolen prescriptions are **NOT COVERED.**

6.57.19 **Restricted Drugs or Drugs Requiring Prior Authorization** by the PPO which have not received such authorization in advance are **NOT COVERED**. The PPO reserves the right to require prior authorization for selected drugs (listed in the Drug Formulary) before providing coverage for such drugs.

6.57.21 **Smoking Cessation Aids**, including but not limited to nicotine replacement drugs (except Chantix™ and Generic Zyban™ (buproban) as described in the Policy are **NOT COVERED**.

6.57.22 **Standard Medical Treatment**. Prescription drugs not accepted as standard medical treatment of the condition being treated as determined by the PPO, or any such drug requiring Federal or other governmental agency approval not granted at the time the drug was dispensed are **NOT COVERED**.

6.57.23 **The Prescription Drugs Suboxone™ and Subutex ™** or any Generic equivalent of these drugs are **NOT COVERED** unless they are prescribed for use in an uninterrupted Short Term acute outpatient Opioid Detoxification treatment program of four (4) continuous months (limited to one (1) uninterrupted period of four (4) months per a Covered Person's lifetime) as specifically set forth in the Policy.

6.57.24 **Unit Doses of Prescriptions**. Prescriptions dispensed in unit doses, when bulk packaging is available, are **NOT COVERED.**

6.57.25 **Use of a Prescription Drug by Anyone other than the Covered Person** listed on the prescription is **NOT COVERED.**

6.57.26 **Weight loss or Weight Management.** Prescription Drugs prescribed for weight loss or weight management are **NOT COVERED** except as set forth in the Policy.

6. 58 THE FOLLOWING DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC DEVICES AND PROSTHETIC DEVICES ARE NOT COVERED:

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

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

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

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

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

6.58.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** of any sort, except for diabetic foot orthotics which are covered as a Covered Service under the Policy, are **NOT COVERED**.

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

6.58.8 **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.**

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

6.58.10 **Experimental or Research Equipment** which, as determined by the PPO, is not accepted as Standard medical treatment of the condition being treated, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device, Orthotic Device or Durable Medical Equipment was provided is **NOT COVERED**. The experimental or non-experimental nature of any Prosthetic Device, Orthotic Device, or Durable Medical Equipment shall be determined by the PPO in accordance with the terms and conditions set forth in the Policy.

6.58.11 **Home Monitoring Equipment** is **NOT COVERED** except for apnea monitors and pulse oximeters which are covered for Covered Person's age seventeen (17) and younger**.**

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

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

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

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

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

6.58.18 **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.**

6.58.19 **Non-Standard Equipment or Devices.** Deluxe equipment or devices of any sort which has been otherwise determined by the PPO to be non-Standard is **NOT COVERED.**

6.58.20 **Repair or Replacement** of any piece of equipment, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in the Policy.

6.58.21 **Replacement of Component Parts or Modification** of a Standard Prosthetic Device unless incident to the Covered Person's growth for a Covered Person who is under the age of nineteen (19) years as set forth in the Policy is **NOT COVERED**.

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

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

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

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

6.59.2 **Durable Medical Equipment, Orthotic Devices and Prosthetic Devices.** Durable medical equipment, Orthotic Devices and Prosthetics Devices obtained from Non-Preferred Providers are **NOT COVERED**.

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

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

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

6.59.6 **Implanted Devices.** Implanted devices obtained from Non-Preferred Providers are **NOT COVERED.**

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

6.59.8 **Mental Health Services or Substance Abuse Services.** Mental health or Substance Abuse services obtained from Non-Preferred Providers are **NOT COVERED.**

6.59.9 **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**.

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

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

6.59.12 **Preventive Services.** Preventive services 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 Covered Person's 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 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 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 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 in 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.