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)"

REQUIRED OUTLINE OF COVERAGE

A. ***Read Your Agreement Carefully.*** This outline provides a very 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"). 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, to persons insured 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; out-of-hospital care; and prosthetic appliances; subject to any deductibles, 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 and Lifetime Maximums. However, benefits for certain services are only available if received from a Preferred Provider. Benefits are subject to utilization review procedures and precertification processes with penalties and possible loss of benefits for non-compliance. Benefits for Emergency Care are provided at the Preferred Provider benefit level.

C. ***A brief description of the benefits contained in the Agreement 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*—including 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; radiation therapy; inhalation therapy; cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer; renal dialysis; administration of whole blood and blood plasma and medical social services. 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*—including pre- and post-operative services and special surgical procedures which include certain oral surgery, restorative or reconstructive surgery and mastectomy and 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 Precertification is obtained from the PPO before the procedure is conducted.

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

6) *Out-of-Hospital Care*—including (a) preventive services such as (i) voluntary family planning services, (ii) periodic health assessments (including physical examinations, annual gynecological and pelvic examinations, breast exam and routine pap smears; and annual screening mammograms for women forty (40) years of age and older and for any provider recommended mammograms for women under age forty (40); (iii) well-child care, and (iv) adult and pediatric immunizations; (b) diagnostic and other outpatient facility services; (c) physical, occupational and speech therapy services; (d) cardiac rehabilitation services; (e) professional mental health and substance abuse services; (f) enteral feeding/food supplements; and (g) diabetes treatment for all types of diabetes.

7) *Prosthetic Appliances*—including prosthetic and orthotic devices and durable medical equipment.

8) Other Benefits—including diagnostic services; injectable drugs; skilled nursing facility services; home health care; transportation services; implanted devices; podiatry services; hospice; diabetic medical equipment, supplies, prescription drugs and services; enteral feeding/food supplements; disease and weight management programs.

a) 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 member, 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 member requires Emergency Services, benefits will be provided at the Preferred services benefit levels. The member will not be responsible for any difference between the PPO payment and the provider's charge.

b) Benefit Amounts, Durations, Limits, Deductibles, Coinsurance and Copayments for Benefits Under the Policy

i. Benefit Period is the initial twelve-month period of time the Policy is in effect as indicated on the Schedule Page and the subsequent twelve-month periods thereafter.

The Schedule Page, 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, Maximum Out-of-Pocket 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 Page (for example, an item has been printed incorrectly or the wrong Schedule Page has been provided), the PPO will issue a new Schedule Page to replace all prior Schedule Pages.

ii. 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.

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.

A 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. 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.

A 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. The 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 phone 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.

Cost-sharing:

Coinsurance is a form of cost sharing 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 Page, after the Deductible has been paid by the Covered Person or Family Unit.

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 Page 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 Maximum Out-of-Pocket or Deductible amounts.

A *Deductible* is 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 Page. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers, as set forth on the Schedule Page. 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. The Outpatient Prescription Drug and Mail Order Drug Rider has a separate Deductible as set forth on the Schedule Page and the terms of the Riders. 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.

iii. 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 Policyholder 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	[$250; $500; $1,000; $2,500] SINGLE [$500; $1,000; $2,000; $5,000] FAMILY	[$500; $750; $1,250; $4,000] SINGLE [$1,000; $1,500; $2,500; $8,000] FAMILY
MAXIMUM OUT-OF POCKET (does not include injectables—see separate maximum out-of-pocket for injectables below)	[$750; $1,500; $3,000; $6,000; $7,500] SINGLE [$1,500; $3,000; $6,000; $12,000; $15,000] FAMILY	[$5,000; $7,500; $10,000; $12,500] SINGLE [$10,000; $15,000; $20,000; $25,000] FAMILY
LIFETIME BENEFIT MAXIMUM	UNLIMITED	$1,000,000 PER MEMBER
INPATIENT HOSPITAL SVCS		
-facility services	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule* (limited to 90 days per Benefit Period)
-physician services	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
OUTPATIENT SURGERY	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
PREVENTIVE SERVICES: Voluntary Family Planning Services Periodic Health Assessments -mammograms -pap smears -Chlamydia screening (female age 16 – 25) -dexa scan -cholesterol screening -lipid panel Well-Child Care -hemoglobin & hematocrit (limited to one service under the age of 24 months) Adult and Pediatric Immunizations Additional Preventive Services -Diabetes Care (age 18 – 75) -HbA1c -LDL-C screening -Nephropathy Screening Test -Colorectal Cancer Screening -fecal occult blood testing -flexible sigmoidoscopy (age 50 and over) -colonoscopy (age 50 and over)	$0 copayment	svcs limited to Preferred Providers

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
DIABETIC EYE EXAM	$45 copayment	svcs limited to Preferred Providers
DIAGNOSTIC AND OTHER OUTPATIENT FACILITY SERVICES	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
INJECTABLES ($1,000 out of pocket maximum per Covered Person per Benefit Period)	10% coinsurance (not subject to Deductible)	svcs limited to Preferred Providers
HUMAN LEUKOCYTE ANTIGEN (HLA) TYPING (limited to $10,000 per Covered Person per approved transplant)	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
MRI/CAT SCAN/PET SCAN	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
PRIMARY CARE OFFICE VISITS	$20 copayment	[30%; 40%] of Non-Preferred Provider Fee Schedule*
SPECIALIST OFFICE VISITS	$45 copayment	[30%; 40%] of Non-Preferred Provider Fee Schedule*
PHYSICIAN OFFICE DIAGNOSTIC SERVICES/PROCEDURES	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
POST-MASTECTOMY RECONST SURG BREAST PROSTHESES	[10%; 20%] coinsurance	svcs limited to Preferred Providers
REHABILITATION SVCS (limited to 45 dates of svc per Covered Person per Benefit Period)	$45 copayment per date of service	[30%; 40%] of Non-Preferred Provider Fee Schedule*
CARDIAC REHABILITATION (limited to 36 sessions per Covered Person per Benefit Period)	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE PROFESSIONAL SERVICES (limited to 10 visits per Covered Person per Benefit Period)		
-individual therapy	$25 copayment per visit	svcs limited to Preferred Providers
-group therapy	$10 copayment per visit	svcs limited to Preferred Providers
HOME HEALTH CARE		
-primary care physician visits	$20 copayment	[30%; 40%] of Non-Preferred Provider Fee Schedule*
-specialist visits	$45 copayment	[30%; 40%] of Non-Preferred Provider Fee Schedule*
-other professional visits	[10%; 20%] coinsurance	[30%; 40%] Non-Preferred of Provider Fee Schedule*
HOSPITAL E.R. VISITS (Copayment waived if admitted)	$150 copayment	$150 copayment
URGENT CARE	$45 copayment	$45 copayment
EMERGENCY TRANSPORTATION SVCS	$150 copayment	$150 copayment

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
SCHEDULED TRANSPORTATION SVCS	$150 copayment	svcs limited to Preferred Providers
IMPLANTED DEVICES (drug delivery, contraception)	25% coinsurance	svcs limited to Preferred Providers
HOSPICE SERVICES ($10,000 maximum benefit per Covered Person per lifetime)	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
DIABETIC EQUIPMENT, SUPPLIES, DRUGS		
-prescription drugs	copayment per outpatient prescription drug rider or 25% coinsurance for members with no prescription drug rider	svcs limited to a participating pharmacy
-diabetic foot orthotics	[10%; 20%] coinsurance	svcs limited to Preferred Providers
-diabetic medical equipment	[10%; 20%] coinsurance	svcs limited to Preferred Providers
SKILLED NURSING (limited to 60 days of any period of confinement per Covered Person)	[10%; 20%] coinsurance	[30%; 40%] of Non-Preferred Provider Fee Schedule*
ENTERAL FEEDING	[10%; 20%] coinsurance (not subject to deductible)	svcs limited to Preferred Providers
DURABLE MEDICAL EQUIPMENT ($2,500 maximum benefit per Covered Person per Benefit Period)	[10%; 20%] coinsurance	svcs limited to Preferred Providers
ORTHOTIC DEVICES	25% coinsurance	svcs limited to Preferred Providers
PROSTHETICS ($5,000 maximum benefit per Covered Person per Benefit Period)	[10%; 20%] coinsurance	svcs limited to Preferred Providers

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

*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 NUMBER INDICATED ON YOUR MEMBER ID CARD.

D. Exceptions, Reductions, and Limitations of the Agreement

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-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's 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 a newborn or adopted child, or a child placed for adoption, during the first thirty-one (31) days from the date of birth, adoption or placement for adoption, subject to the Continuation of Benefits provision of Section 8—General Provisions of the Policy. The Pre-Existing Condition Exclusion Period will not be applied thereafter provided that such child is enrolled within thirty-one (31) days from the date of birth, adoption or placement 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 planned and urgent 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.

   For services and procedures that require Precertification the following shall apply:

   i) 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) 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 Covered Person 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, no benefits will be provided for the following:

a.) *Insured Obligations.* Amounts for any Covered Service which are greater than PPO's then current Non-Preferred Provider Fee Schedule Amount (except with respect to costs associated with Emergency Services) or exceed the Lifetime Benefit Maximum set forth on the Schedule Page, or amounts for any Covered Service which are applied toward satisfaction of the Copayment, Deductible or Coinsurance amounts; or which exceed the specific benefit limits set forth on the Schedule Page.

b.) *Government Responsibility.* Care for military service related disabilities if the care is being provided in a U.S. Military Facility for which the Member does not incur a legal responsibility to pay for such services are not covered.

c.) 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.

d.) *Manipulative Treatment Services.* Manipulative Treatment Services are not covered. Manipulative Treatment Services are services rendered for the treatment or diagnosis of neuromusculoskeletal disorders.

e.) *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. This exclusion does not apply to restorative or reconstructive surgery or mastectomy reconstructive surgery as provided in the Policy.

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

g.) *Custodial, Convalescent or Domiciliary Care.* Custodial, Convalescent or Domiciliary Care Services are not covered.

h.) *Dentistry.* Dental care including, but 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 is not covered unless for expenses otherwise covered on account of accidental injury to otherwise sound natural teeth.

Implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth are not covered.

i.) *Maxillary or Mandibular Osteotomies.* Maxillary or mandibular osteotomies are not covered except when performed to correct dislocation or complete degeneration of the TM joint, as provided for in the Policy.

j.) *Personal Comfort Items/Services.* Personal comfort items and services including but not limited to, telephones, televisions and special meals are not covered.

k.) *Experimental, Investigational or Unproven Services.* Experimental, Investigational or Unproven Services are not covered.

l.) *Sex Transformation.* Transplants, implants, procedures, services and supplies related to sex transformation are not covered.

m.) *Drugs.* Prescription drugs provided on an outpatient basis are not covered unless expressly set forth in the Policy or unless the Outpatient Prescription Drug and Mail Order Drug Rider has been purchased.

n.) *Reversal of Sterilization.* Surgical procedures to reverse voluntary sterilization are not covered.

o.) *Routine Nail Trimming.* Routine nail trimming is not covered.

p.) *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.

q.) *Illegal Activity.* 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.

r.) *Refractions***.** Examinations to determine the refractive error of the eye are not covered.

s.) *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.

t.) *Drugs and Devices for Purposes of Contraception.* Drugs and devices for purposes of contraception are not covered except implanted devices as provided in the Policy.

u.) *Riot or Insurrection.* Covered Services required as a result of a Covered Person's participation in a riot or insurrection, are not covered.

v.) *Mental Health Services, Detoxification and Substance Abuse Rehabilitation Services.* (a) Mental health inpatient, partial hospitalization, and electroconvulsive therapy and other outpatient facility services and their related professional services, (b) inpatient detoxification services, and (c) Substance Abuse residential, partial hospitalization and other facility services and their related professional services are not covered.

w.) *Private Duty Nursing.* Hourly nursing care on a private duty basis is not covered.

x.) *Hair Removal.* Hair removal is not covered.

y.) *Revision of the External Ear.* Revision of the external ear is not covered.

z.) *Vein Sclerosing and Vein Stripping.* 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 specific medical criteria as determined by the PPO are met. Vein stripping is not covered unless specific medical criteria as determined by the PPO are met.

aa.) *Missed Appointment Charge.* Charges for missed appointments by a Member are not covered**.**

bb.) *Refractive Procedures.* Any surgery to correct the refractive error of the eye is not covered.

cc.) *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.

dd.) *Panniculectomy, Lipectomy, Liposuction, Abdominoplasty.* Excision of excessive skin and subcutaneous tissue including but not limited to (1) panniculectomy (abdominoplasty) or (2) lipectomy by any method (suction assisted, liposuction, 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, hips and other areas not specifically listed.

ee.) *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.

ff.) *Orthoptic Therapy.* Orthoptic therapy (vision exercises) is not covered.

gg.) *Hypnosis***.** Hypnosis is not covered.

hh.) *Weight Control.* Weight reduction programs for non-morbid obesity are not covered unless as provided for in the Policy.

ii.) *Transportation Services.* Stretcher/wheelchair van transportation and transportation services that are Not Medically Necessary are not covered.

jj.) *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**.**

kk.) *Travel Expenses for Transplant Services.* Travel expenses for transplant services are not covered**.**

ll.) *Batteries Required for Diabetic Medical Equipment.* Batteries required for diabetic medical equipment are not covered**.**

mm.) *Biofeedback***.** Biofeedback is not covered**.**

nn.) *Organ Donation to Non-Members.* All costs and services related to a Covered Person donating organ(s) to a non-Covered Person are not covered.

oo.) *Acupuncture.* Acupuncture is not covered.

pp.) *Podiatry Services.* Treatment of bunions (except capsular or bone surgery), corns, calluses, warts, fallen arches, flat feet, weak feet, chronic foot strain (except for diabetic conditions) is not covered.

qq.) *Services Provided by a Covered Person's Relative or Self.* Services rendered by a person who is the spouse, child, parent, 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.

rr.) *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.

ss.) *All Non-Emergency Inpatient Hospital Admissions and Certain Designated Procedures and Services Set Forth in the Policy, for Which Precertification is Not Obtained.* All non-emergency inpatient hospital admissions and certain designated procedures and services set forth in the

Agreement, for which Precertification is required but not obtained prior to the provision of such services are not covered**.**

tt.) *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**.**

uu.) *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.

vv.) THE FOLLOWING SERVICES ARE NOT COVERED WHEN OBTAINED FROM NON-PREFERRED PROVIDERS:

1) *Mental Health Services or Substance Abuse Obtained from Non-Preferred Providers.* Mental Health or Substance Abuse Services obtained from Non-Preferred Providers are not covered.

2) *Organ, Bone Marrow, Stem Cell or Corneal Transplants, Evaluation and Related Services Obtained from Non-Preferred Providers.* Organ, bone marrow, stem cell or cornel transplants, evaluation and related services obtained from Non-Preferred Providers are not covered.

3) *Diabetic Medical Equipment, Blood Glucose Meters, 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) Obtained from Non-Preferred Providers.* 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.

4) *Enteral Feedings/Food Supplements Obtained From Non-Preferred Providers.* Enteral feedings/food supplements obtained from Non-Preferred Providers are not covered.

5) *Podiatric Services Obtained From Non-Preferred Providers.* Podiatric services obtained from Non-Preferred Providers are not covered**.**

6) *Genetic Counseling and Testing.* Genetic counseling and testing obtained from Non-Preferred Providers are not covered**.**

7) *Pain Management.* Pain Management services obtained from Non-Preferred Providers are not covered.

8) *Implanted Devices.* Implanted devices obtained from Non-Preferred Providers are not covered.

9) *Durable Medical Equipment, Orthotic Devices and Prosthetics.* Durable medical equipment, orthotic devices and prosthetics obtained from Non-Preferred Providers are not covered.

10) *Injectables.* Injectables obtained from Non-Preferred Providers are not covered.

11) *Preventive Services.* Preventives services obtained from Non-Preferred Providers are not covered.

ww.) 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.

xx.) *Surgery for Treatment of Morbid Obesity.* Surgical treatment of morbid obesity is not covered.

yy.) *Maternity Care.* Except for complications of pregnancy, maternity care is not covered, unless the Maternity Rider has been purchased.

zz.) 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.

aaa.) Any type of drug, service, supply or treatment for which the Covered Person would have no legal obligation to pay is not covered.

E. 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 E.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:

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

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

i) If payment of the appropriate premium is not made when due, or during the grace period;

ii) If a member 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 member 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;

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

iv) In the event the Policyholder no longer lives in the Service Area.

v) 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 Section 6.4 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 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 Questionnaire would have resulted in a different initial premium, in which case Geisinger Quality Options, Inc. 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 Section 8.21.2 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.