



PPO with No Referral High Deductible Health Plan

Subscription Certificate

This Direct Access High Deductible Health Plan Preferred Provider Organization contract, called Geisinger Choice PPO with no Referral High Deductible Health Plan, provides hospital, medical-surgical and extended benefits utilizing Preferred Provider Networks to maximize benefits. This plan is a qualified High Deductible Health Plan for use with a Health Savings Account as defined by the Internal Revenue Service. With this PPO, Covered Services provided by Non-Preferred Providers will generally subject the Member to an additional Coinsurance liability, except for outpatient Emergency Services or when Covered Services are not available from a Preferred Provider. In such instances, coverage increases to the Preferred Provider level of coverage. In the event that the Member requires Emergency Services, the PPO will provide coverage at the Preferred Provider level to a Non-Preferred Provider and the Member's out-of-pocket expense will be no greater than the amount that would have been incurred if the Member had been able to choose a Preferred Provider.

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

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

GEISINGER CHOICE PPO WITH NO REFERRAL
HIGH DEDUCTIBLE HEALTH PLAN
Group Subscription Certificate

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

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

In addition, this PPO is intended to meet the necessary federal Deductible and out-of-pocket requirements to be combined with a Health Savings Account (HSA). Members choosing to combine this High Deductible Health Plan with an HSA are responsible for understanding and adhering to the regulations established by the federal government and the selected HSA administrator or banking partner. Such information may be available through the Member’s employer or through the HSA administrator.

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

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

The PPO issues these documents in accordance with the terms of a Certificate of Authority awarded by the Pennsylvania Insurance Department and Pennsylvania Department of Health. Together, the Certificate and any Amendments, Riders (if any), the Schedule of Benefits, the Enrollment Application and the Enrollment Letter constitute the entire agreement between the Subscriber named on the Schedule of Benefits and the PPO. In addition, these documents specify the coverage extended to the Subscriber and Family Dependents in consideration of the specified premiums paid by them or on their behalf. The Certificate and all Amendments, Riders (if any), the Schedule of Benefits and the Enrollment Application remain in effect as long as the Group

Master Policy remains in effect, or until such time that a Member's coverage may be terminated in accordance with the termination provisions outlined in the Certificate.

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

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

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

Needs of non-English speaking enrollees: If a non-English speaking Member calls the Customer Service Team for assistance, an appropriate interpreter will be provided to translate for the Customer Service Team representative and the Member.

IN WITNESS WHEREOF,

Geisinger Quality Options, Inc.
has duly executed this Certificate



Kurt J. Wrobel
President
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220



John B. Bulger, DO, MBA
Chief Medical Officer
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220

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SECTION 1. DEFINITIONS

1. **GENERAL DEFINITIONS.** The following terms, when used in this Certificate and all applicable Amendments, Riders, and Schedule of Benefits, will have the meanings assigned to them below unless these terms are otherwise defined in such other applicable documents (please note that these terms will be capitalized when used in document text):
 - 1.1 **Advance Health Care Directive** means a writing made in accordance with legal requirements that expresses a person's wishes and instructions for health care and health care directions when the person is determined to be incompetent and has an end-stage medical condition or is permanently unconscious. An Advance Health Care Directive could also be a writing made by a person designating an individual to make health care decisions for them should they be incapacitated or incompetent.
 - 1.2 **Ambulatory Surgical Center** means a facility, or portion thereof, not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment. This does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.
 - 1.3 **Amendment** is any document that describes changes to Covered Services or changes to the terms and conditions of coverage, which have become necessary between printings of the Certificate and which is executed by an officer of the PPO and is to be attached to and made a part of the Certificate.
 - 1.4 **Benefit Limit** means a specific limitation on a benefit which is set forth in the Schedule of Benefits, Rider(s) and/or in the Certificate as an age requirement, dollar amount or number of services covered per Benefit Period.
 - 1.5 **Benefit Period** means the period of time this Certificate is in effect as indicated on the Schedule of Benefits.
 - 1.6 **Certificate** refers to this document, which is provided by the PPO to all Subscribers awarded Group coverage. The Certificate describes the Covered Services and the terms and conditions of coverage.
 - 1.7 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time, that provides continuation coverage to Members who incur certain qualifying events (as defined under COBRA).
 - 1.8 **Coinsurance** is a form of Cost Sharing (indicated as a percentage amount on the Schedule of Benefits) which requires the Member to pay a specified portion of the Preferred Provider Fee Schedule Amount or the Non-Preferred Provider Fee Schedule Amount, as set forth on the Schedule of Benefits, after the Deductible has been paid by the Member or Family Unit. Coinsurance amounts accrue toward satisfaction of any DCC Maximum amounts.
 - 1.9 **Commissioner** means the Insurance Commissioner of the Commonwealth of Pennsylvania.
 - 1.10 **Copayment** is a form of Cost Sharing which requires the Member 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 Member. Copayment amounts accrue toward satisfaction of any DCC Maximum amounts. Once the DCC Maximum has been met, no more further Copayment amounts are required to be paid by the Member.

- 1.11 Cost Sharing** means the Deductible, Copayment, Coinsurance and any amounts exceeding the DCC Maximums, Benefit Limits or Lifetime Benefit Maximum amounts that a Member will incur as an expense for Covered Services. Specific Cost Sharing amounts for Covered Services can be found on the Schedule of Benefits and as to Benefit Limits, also in the Certificate and/or any Riders supplementing the Certificate.
- 1.12 Covered Service** means:
- a) a Medically Necessary (unless otherwise indicated) service or supply specified in this Certificate for which benefits will be provided pursuant to the terms of the Certificate or
 - b) any Medically Necessary Supplemental Health Services set forth in any Riders supplementing this Certificate.
- 1.13 Creditable Coverage** means the length of time an enrollee had previous continuous health coverage was not interrupted by a sixty-three (63) day break in coverage. This coverage may be credited against, and reduce the length of, any Pre-Existing Condition exclusion that may be applied by the PPO in accordance with HIPAA.
- 1.14 Custodial, Domiciliary or Convalescent Care** means services to assist an individual in the activities of daily living that do not require the continuing attention of skilled, trained medical or paramedical personnel.
- 1.15 Customer Service Team** refers to the PPO representatives who are available to answer Member's questions and provide information regarding the PPO and coverage. The telephone number for the Customer Service Team is set forth on the back of the Member's Identification Card.
- 1.16 Deductible** means a specified dollar amount as set forth on the Schedule of Benefits for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the PPO will assume any liability for all or part of the cost of Covered Services. The Deductible applies to each Member subject to any Family Deductible set forth on the Schedule of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers, as set forth on the Schedule of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Preferred Providers or Preferred Providers do not accrue toward each other. In addition, certain Supplemental Health Services may have a separate Deductible as set forth on the Schedule of Benefits and the terms of the applicable Rider. Deductible amounts must be met every Coverage Period before the corresponding Coinsurance or Copayment amount applies. Deductible amounts accrue toward satisfaction of any DCC Maximum amounts. Copayment amounts do not accrue towards satisfaction of any Deductible amounts.
- 1.17 Deductible, Coinsurance and Copayment Maximum ("DCC Maximum")** means the maximum dollar amount in the form of Deductible, Coinsurance and Copayments that a Member or Family Unit will be required to pay in a given Benefit Period for Covered Services, as set forth on the Schedule of Benefits. The DCC Maximum does not include the following:
- (i) amounts above a specific Benefit Limit as set forth in the Policy and/or Schedule of Benefits;
 - (ii) amounts above the Lifetime Benefit Maximum as set forth on the Schedule of Benefits;

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

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

Please note that there are separate DCC Maximums for Preferred and Non-Preferred Providers. Deductible, Coinsurance and Copayment amounts paid for Covered Services provided by a Non-Preferred Provider accrue toward the Non-Preferred Provider DCC Maximum and the Preferred Provider DCC Maximum. However, Deductible, Coinsurance and Copayment amounts paid for Covered Services provided by Preferred Providers **do not** accrue toward the Non-Preferred Provider DCC Maximum.

Please note also that this term, "DCC Maximum" is meant to encompass the same annual Deductibles, Copayments and other amounts referred to in the Federal Regulations governing High Deductible Health Plans as "annual out-of-pocket limitations".

- 1.18 Designated Behavioral Health Benefit Program** means a program in which the PPO manages behavioral health services (including inpatient and outpatient mental health care and Substance Abuse care). The Member must access care directly through the Designated Behavioral Health Benefit Program for coverage, subject to limitations or exceptions set forth in this Certificate or in any applicable Riders.
- 1.19 Designated Transplant Facility** is a facility that has entered into an agreement with the PPO, the PPO's transplant subcontractor or national organ transplant network to provide transplant services when a transplant service as set forth in Section 3.29 is Medically Necessary for a Member. The Designated Transplant Facility is determined by the PPO or the PPO's transplant subcontractor and may or may not be located in the Service Area.
- 1.20 Durable Medical Equipment (DME)** means equipment designed to serve a medical purpose and which is not generally useful to a person in the absence of illness or injury, is able to withstand repeated use, is not a disposable or single patient use and is required for use in the home.
- 1.21 Emergency Service** means any health care service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - a) placing the health of the Member, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy;
 - b) serious impairment to bodily functions; or
 - c) serious dysfunction of any bodily organ or part.Transportation and related Emergency Services provided by a licensed ambulance service shall constitute an Emergency Service if the condition is as described in this definition.
- 1.22 Enrollment Application** refers to the form(s) completed by the applicant for enrollment purposes.

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

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

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

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

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

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

1.27 Family Unit means the Subscriber and his or her Family Dependents.

1.28 Group means the employer, association, union or trust through which the Subscriber is enrolled and who agrees to remit premiums for coverage payable to the PPO. The Group is identified on the Schedule of Benefits.

1.29 Group Master Policy means the agreement between the PPO and the Group providing for the administration of enrollment, payment of premiums, and other matters pertaining to the provision of health care benefits under the terms of this Certificate for persons who meet the requirements of the Group to participate in the Group's health benefit's plan.

1.30 Health Care Provider or Provider means a licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under any applicable law, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

1.31 Health Insurance Portability and Accountability Act of 1996 (HIPAA) as may be amended from time to time, is a federal law including, but not limited to, the following:

- a) limiting exclusions for Pre-Existing Conditions (as defined under HIPAA);
- b) prohibiting discrimination against employees and dependents based on their health status;
- c) guaranteeing renewability and availability of health coverage to certain employers and individuals;
- d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and
- e) regulating the use and disclosure of protected health information.

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

1.32.1 Continuous Care means a level of continuous and uninterrupted care which is:

- a) necessary due to periods of crisis resulting from a Member's deteriorating medical condition and/or the Member's family's inability to provide the level of care necessary to maintain the Member at home; and
- b) provided in the Member's home by qualified professionals for a period of at least eight (8) hours until such care is deemed no longer Medically Necessary by the PPO.

1.32.2 General Inpatient Care means a level of care involving Hospice-supervised inpatient services in accordance with the Member's Plan of Care including, without limitation, services necessary for pain control or symptom management during one (1) or more days, including overnight stays, in an inpatient setting to include either a hospital, skilled nursing facility, or hospice inpatient facility.

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

- 1.34 Legal Custody** means the legal right to make major decisions affecting the best interest of a minor including, but not limited to, medical, religious and educational decisions pursuant to 23 Pa. C.S.A. Section 5302.
- 1.35 Legal Guardian or Legal Guardianship** means the appointment of a guardian by a court of an incapacitated person pursuant to 20 Pa. C.S.A. Section 5521.
- 1.36 Level 1 Bariatric Center of Excellence** is an institution which meets certain accreditation standards and is designated by either the American Society of Bariatric Surgery or American College of Surgeons as a Level 1 Bariatric Center of Excellence.
- 1.37 Lifetime Benefit Maximum** means the maximum amount of Covered Services that the PPO will cover during a Member's lifetime under this Certificate, as set forth on the Schedule of Benefits. This could be expressed in dollars, number of days or number of services.
- 1.38 Maximum Age** means the point in time which a Family Dependent is no longer eligible for coverage, as described in Section 6.2 of this Certificate and set forth on the Schedule of Benefits.
- 1.39 Medical Director** means the licensed physician designated by the PPO to direct the medical and scientific aspects of the PPO, and to oversee the quality and appropriateness of the managed health services.
- 1.40 Medical Necessity or Medically Necessary** means Covered Services rendered by a Health Care Provider that the PPO determines are:
- a) appropriate for the symptoms and diagnosis and treatment of the Member's condition, illness, disease or injury;
 - b) provided for the diagnosis, and the direct care and treatment of the Member's condition, illness, disease or injury;
 - c) in accordance with current standards of good medical treatment practiced by the general medical community;
 - d) not primarily for the convenience of the Member, or the Member's Health Care Provider; and
 - e) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.
- 1.41 Medicare** means the programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.
- 1.42 Member** means an individual eligible to receive Covered Services or benefits under the terms of this Certificate either as the Subscriber or an eligible enrolled Family Dependent.
- 1.43 Network** means the Health Care Providers who have entered into a written agreement with the PPO to provide Covered Services to Members as part of the PPO's panel of Preferred Providers.

- 1.44 Non-Preferred Provider** means a Health Care Provider or Provider that does not have an agreement with the PPO to provide Covered Services to the PPO's Members and is not part of the PPO's Network.
- 1.45 Non-Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Non-Preferred Provider which is generally a percentage of Medicare reimbursement. The Member may obtain the Non-Preferred Provider Fee Schedule Amount by contacting the Customer Service Team at the telephone number set forth on the back of the Member's Identification Card.
- 1.46 Open Enrollment Period** means those periods of time established by the Group and the PPO from time to time, during which eligible persons may enroll.
- 1.47 Orthotic Device** means a rigid appliance or apparatus used to support, align or correct bone and muscle deformities.
- 1.48 Precertification** means the process detailed in Section 2.3.1 of this Certificate whereby all non-emergency inpatient hospital admissions or designated procedures and services as listed in Section 2.3 of this Certificate are reviewed by the PPO for coverage determination based on Medical Necessity prior to the provision of services.
- 1.49 Pre-Existing Condition** means a limitation or exclusion of benefits relating to a condition (mental or physical) regardless of the cause of the condition, for which medical advice, diagnoses, care, or treatment was recommended or received within one hundred eighty (180) days immediately prior to the enrollment date.
- 1.50 Preferred Facility Provider** means a hospital, facility or institution licensed, certified or otherwise regulated under the laws of the Commonwealth of Pennsylvania, or another state as applicable, that has an agreement with the PPO to provide Covered Services to Members as a Preferred Provider.
- 1.51 Preferred Provider or Preferred Health Care Provider** means a Health Care Provider that has an agreement with the PPO pursuant to which negotiated rates are established on a Preferred Provider basis for payment of Covered Services to Members under this Certificate and pursuant to which such Health Care Provider is a part of the PPO's Network. PPO contracts with a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Preferred Providers.
- 1.52 Preferred Provider Fee Schedule Amount** means the amount of reimbursement that will be provided by the PPO for Covered Services rendered by a Preferred Provider based on the contractual arrangement between the PPO and the Preferred Provider which shall constitute payment in full for the Covered Services. Any Deductibles, Coinsurance and Copayments shall be the responsibility of the Member.
- 1.53 Preferred Provider Organization (PPO)** means Geisinger Quality Options, Inc.
- 1.54 Primary Care Services** means initial and basic medical health care services provided by a general or family care practitioner, internist or pediatrician.
- 1.55 Prosthetic Device** means an appliance or apparatus which replaces a missing body part.

- 1.56 Provider.** A Preferred or Non-Preferred Provider, including a physician, medical group, pharmacy, hospital, or other provider of health services, licensed, certified or otherwise regulated under any applicable law.
- 1.57 Provider List** means a published listing (as amended from time to time) provided to Members by the PPO which sets forth the names, addresses and telephone numbers of current Preferred Providers who have contracted with the PPO to provide Covered Services. The current Provider List can be found on the PPO's Web site (at www.thehealthplan.com). A Member may also request a copy of the most current Provider List by calling the Customer Service Team at the telephone number on the back of the Member's Identification Card or by writing to the Customer Service Team at the address listed on page (iii) of this Certificate.
- 1.58 Rider** means a document that describes the terms and conditions applicable to specific Supplemental Health Services purchased by the Group to be in effect for the Subscriber and all Family Dependents enrolled under this Certificate. All Riders in force under this Certificate are listed on the current Schedule of Benefits.
- 1.59 Schedule of Benefits** is a summary of coverage for a Member that identifies the Members and the Maximum Age for dependent coverage together with the applicable Deductible, Copayments, Coinsurance, DCC Maximums, Benefit Limits and Lifetime Benefit Maximum amounts for Covered Services, and any Riders in force for the Certificate. If there is a change in any of the information printed on the Schedule of Benefits (for example, an item has been printed incorrectly or the wrong Schedule of Benefits has been provided), the PPO will issue a new Schedule of Benefits to replace all prior Schedules of Benefits.
- 1.60 Service Area** means the Pennsylvania counties listed in Exhibit 1, as amended from time to time, for which the PPO is licensed to operate by the Pennsylvania Department of Health.
- 1.61 Specialist** means a Provider whose practice is not limited to Primary Care Services and who has additional post graduate or specialized training, board certification or practices in a licensed specialized area of health care.
- 1.62 Subscriber** means an individual who meets the requirements for eligibility, who has enrolled in the PPO, and for whom payment has actually been received by the PPO. A Subscriber is also a Member.
- 1.63 Substance Abuse** means any use of drugs and/or alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- 1.64 Supplemental Health Services** are those benefits provided under the Riders listed on the Schedule of Benefits.
- 1.65 Tel-A-Nurse** is the twenty-four (24) hour a day access to nurse advice available to Members by the toll-free number set forth on the Member's Identification Card or by "live chat" on the PPO's Web site at www.thehealthplan.com. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.
- 1.66 Urgent Care** means any Covered Service provided to a Member in a situation which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency Service as it allows the Member to consider alternative settings of care.

SECTION 2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS

2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS.

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

- a) Non-emergency inpatient admissions and certain designated services and procedures identified in this Section received from Non-Preferred Providers or Preferred Providers **REQUIRE** Precertification by the PPO as set forth in this Section.
- b) The PPO case management nursing staff is available to work with Members who require transplants, who have catastrophic disease or injury, who are temporarily outside the Service Area and require Urgent Care, who can benefit from individualized attention to coordinate their needs, or who are otherwise recommended for case management.
- c) The PPO medical management staff coordinates with the quality improvement staff to collect data and review issues to assure appropriate care in the most efficient manner.
- d) Concurrent review (a review of the Member's care while under an ongoing course of treatment) may be required for services such as, but not limited to, inpatient admissions (including emergencies and admissions where the PPO is not the primary payor), home health care and outpatient rehabilitation. Concurrent review is the responsibility of the facility, not the Member.
- e) A PPO Medical Director will be involved in any decision to deny coverage on the basis of Medical Necessity.

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

2.2 Precertification. The purpose of Precertification is to encourage and facilitate use of the most appropriate level of care for Medically Necessary services utilizing industry accepted criteria for severity of illness and intensity of service. Precertification does not verify a Member's coverage by the PPO or guarantee payment. Precertification is required even when the PPO is not the primary carrier.

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. COVERED SERVICES

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

Please be advised that the benefits set forth in this Section 3 and in any Riders for Supplemental Health Services, if any such Riders have been purchased, are subject to the Deductible and Copayment or Coinsurance, DCC Maximum and Lifetime Benefit Maximums that are specifically set forth on the Schedule of Benefits as well as the individual Benefit Limits set forth in Section 3, Riders and on the Schedule of Benefits. Preventive Services as set forth in Section 3.22 of this Certificate are not subject to any Deductible.

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

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

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

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

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

3.1.2 The PPO's Coverage of Covered Services:

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

- 3.1.2.2 Covered Services Obtained Outside the Service Area.** Covered Services required as a result of circumstances that reasonably could have been foreseen prior to the Member's departure from the Service Area and Covered

Services which can be delayed until the Member's return to the Service Area are covered at the Non-Preferred Provider rate.

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

3.1.3 Covered Service Location Cost Sharing. Certain benefits (as indicated on the Member's Schedule of Benefits) will subject the Member to Cost Sharing based on the type of facility where the Covered Service is provided. This Cost Sharing is in addition to any Cost Sharing obligation for the Covered Service being provided to the Member.

3.1.4 Supplemental Health Services as set forth in Rider(s). The Member's Schedule of Benefits will list any Rider(s) supplementing this Certificate as well as the Member's Cost Sharing obligations related to the Rider(s). Members should note that the conditions listed above in Sections 3.1.1, 3.1.2 and 3.1.3 will also apply to the Supplemental Health Service Benefits set forth in the Rider(s). The terms and conditions of each Rider will detail how these Sections apply to the Supplemental Health Services provided by the Rider. If a Rider is listed as an exception to a Benefit in this Section 3, the Member should pay particular attention to the terms of that Rider (if in force with their Certificate) as the benefit will differ from that listed in this Section.

IDENTIFICATION OF COVERED SERVICES

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

3.2 Cardiac Rehabilitation. Cardiac rehabilitation on an outpatient basis is covered for up to thirty-six (36) sessions per Benefit Period.

3.3 Diabetic Medical Equipment, Supplies, Prescription Drugs and Services. The following diabetic medical equipment, supplies, prescription drugs and services for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are covered when provided in accordance with an approved treatment plan established and provided by a Preferred Provider. The PPO reserves the right to approve the preferred manufacturer of diabetic medical equipment, supplies, blood glucose monitors, diabetic foot orthotics and prescription drugs.

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

3.3.2 Diabetic Foot Orthotics. The PPO will cover diabetic foot orthotics only when provided by a Preferred Provider.

3.3.3 Prescription Drugs. The PPO will cover insulin and oral pharmacological agents for controlling blood sugar as prescribed by a Preferred Provider as well as.

disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips).

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

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

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

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

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

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

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

- a) **Compliance or Compliant** means a Member's willingness to follow a prescribed course of treatment. Coverage of DME is contingent upon a Member's Compliance in using the equipment as indicated in the course of treatment as determined by the PPO.
- b) **Deluxe Equipment** is equipment which has features that do not contribute significantly to the therapeutic function of the equipment, are only primarily beneficial in performing leisure or recreational activities or are essentially non-medical in nature.
- c) **Related Supplies** means medical supplies which are required to support the use of covered DME.
- d) **Standard** means possessing qualities or attributes which are determined by the PPO to be: (i) Medically Necessary (in the absence of PPO criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations); (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available.

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

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

3.6.2.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Standard DME covered under this Certificate. Such restriction is subject to change by the PPO without the consent or concurrence of the Member except as provided for herein.

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

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

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

3.6.4.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Standard Prosthetic Devices covered under this Certificate. Such restriction is subject to change by the PPO without the consent or concurrence of the Member, except as provided for herein.

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

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

3.7.1 **Emergency Services Protocol.**

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

3.7.2 **Non-Preferred Provider Limitations.** If a Member requires Emergency Services and cannot be attended to by a Preferred Provider, the PPO shall pay for the Emergency Services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a Preferred Provider. However, Emergency Services provided by Non-Preferred Providers will be covered at this level only until the PPO determines the Member's condition has stabilized and the Member's care can be transferred to a Preferred Provider without suffering detrimental consequences or aggravating the Member's condition. Such transportation is not subject to the Cost Sharing amount (as set forth on the Schedule of Benefits) normally applied to transportation services. The Member may continue to use the Non-Preferred Provider at the Non-Preferred Provider rates.

3.7.3 **Cost Sharing.** Emergency Services are subject to the Cost Sharing amounts specified on the Schedule of Benefits. The Deductible, Copayment or Coinsurance will be waived if Emergency Services rendered in the emergency department of an

acute care hospital result in the immediate admission of the Member to the hospital as an inpatient and the requirements for Emergency Services as set forth in Section 1.21 of the Certificate and this Section 3.7 are satisfied.

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

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

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

- 3.11.1 **Hospice Benefit Election.** The Member shall have the option to elect to receive Hospice benefits as set forth in this Certificate. By electing to receive the Hospice benefit, the Member acknowledges that he:
- a) shall not receive curative care but rather palliative care solely for reducing the intensity of and management of the Member's Terminal Illness;
 - b) waives the right to the PPO standard benefits for treatment of the Terminal Illness and related conditions; and
 - c) retains all normal coverage, as set forth in the Member's Subscription Certificate, for Covered Services not related to the Terminal Illness.
- 3.11.2 **Limitations.** The maximum amount which the PPO will pay for all Hospice benefits provided hereunder to any one (1) Member is set forth on the Member's Schedule of Benefits. Covered Services provided which are unrelated to the Member's Terminal Illness shall not be covered under the PPO Hospice benefits, but shall be covered as set forth in the applicable provisions of the Member's Certificate.

3.12 Hospital and Ambulatory Surgical Center Services.

- 3.12.1 **Benefits.** Hospital benefits may be provided at a hospital Provider on either an inpatient or outpatient basis or at an Ambulatory Surgical Center. Hospital services include semi-private room and board (private room when determined Medically Necessary by the PPO), general nursing care and the following additional facilities, services and supplies as prescribed by a physician Provider: use of operating room and related facilities; use of intensive care unit or cardiac care unit and services; radiology, laboratory, and other diagnostic tests; drugs, medications, and biologicals; anesthesia and oxygen services; physical therapy, occupational therapy and speech therapy (subject to the Benefit Limits set forth in this Certificate in Section 3.24 and on the Schedule of Benefits); radiation therapy; inhalation therapy; renal dialysis; administration of whole blood and blood plasma and medical social services; cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.
- 3.12.2 **Precertification.** All non-emergency inpatient hospital admissions require Precertification as detailed in Section 2.3.1 of this Certificate.
- 3.12.3 **Duration of the Benefit.** Inpatient benefits are provided for as long as the hospital stay is determined to be Medically Necessary by the PPO and not determined to be Custodial, Convalescent or Domiciliary Care, except for mastectomy Covered Services as set forth in Section 3.14 of this Certificate. In addition, the number of inpatient days when utilizing a Non-Preferred Provider is specified on the Schedule of Benefits.

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

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

3.13.2 Cost Sharing. Implanted devices for purposes of drug delivery and contraception are covered subject to the Cost Sharing amounts specified on the Schedule of Benefits. Implanted devices not for purposes of drug delivery or contraception (such as cardiac assistive devices, cochlear implants and artificial joints) are covered subject to the Cost Sharing amounts specified on the Schedule of Benefits; however, such implanted devices are not subject to applicable implanted device Copayment or Coinsurance amounts set forth on the Schedule of Benefits.

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

- a) reconstruction of the breast on which the mastectomy was performed; and
- b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c) initial and subsequent Prosthetic Devices to replace the removed breast or portions thereof following a mastectomy will be provided; and
- d) treatment of physical complications at all stages of the mastectomy including lymphedemas.

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

3.15 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the Provider. Certified licensed nurse midwife Provider services shall be covered only if provided in a hospital Provider or an appropriately licensed free-standing birthing center Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.18 of this Certificate.

3.16 Mental Health and Substance Abuse Services.

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

3.16.1 Mental Health Services (Members of Groups with fifty (50) or less employees). All professional mental health Covered Services must be obtained from a psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professional who participates with the PPO's Designated Behavioral Health Benefit Program. A Member may access mental health Covered Services in the following manner:

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

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

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

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

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

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

the maximum dollar amount per hospital admission set forth on the Schedule of Benefits.

3.16.2.2.2 Benefit Limit and Lifetime Benefit Maximum (Admissions).

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

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

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

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

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

3.16.4.1 Non-Hospital Residential Inpatient Rehabilitation for Substance Abuse.

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

- a) a Benefit Limit of thirty (30) days per Benefit Period; and
- b) a total Lifetime Benefit Maximum of ninety (90) days per a Member's lifetime.

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

- a) a Benefit Limit of thirty (30) outpatient, full-session visits or equivalent partial visits each Benefit Period; and

- b) are limited to a Lifetime Benefit Maximum total of one hundred-twenty (120) outpatient full-session visits or equivalent partial visits per a Member's lifetime.

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

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

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

3.17 Mental Health and Substance Abuse Services.

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

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

- a) as a hospital inpatient as set forth in Section 3.21.2 (b) of this Certificate;
- b) as an outpatient;
- c) pursuant to the terms and conditions of the following Riders if they are in force with the Member's Certificate:

- 1) Non-Serious Inpatient Mental Illness Services (Mental Health Parity - Groups of 51 or More);
- 2) Serious Mental Illness Services (Mental Health Parity - Groups of 51 or More); and/or
- 3) Autism Spectrum Disorder Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.21 Physician Services.

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

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

- b) **Ambulatory Surgical Center.** The services set forth in Section 3.12.1 of this Certificate are Covered Services when provided in an Ambulatory Surgical Center setting by physician Providers (or other physicians in response to an emergency) or under the orders of a physician.

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

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

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

- a) all preventive, diagnostic and treatment services listed below in Section 3.22 under Preventive Services in this Certificate;
- b) cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer;
- c) injectable drugs when determined by the Provider to be an integral part of care rendered by the Provider during a visit, and is limited to the amount of drug administered during the visit. Section 2 of this Certificate sets forth the list of agents/medications requiring Precertification by the PPO;
- d) diagnostic and treatment Covered Services provided by a Specialist; and
- e) Medically Necessary Covered Services upon Precertification by the PPO received from Providers who are Non-Preferred Providers when the Member's medical condition requires Covered Services that cannot be provided through Preferred Providers and/or certain procedures and services designated by the PPO. These services shall be covered at the Preferred Provider rate.

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

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

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

3.22.1 Periodic health assessments including:

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

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

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

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

3.22.3 **Pediatric and Adult Immunizations**, in accordance with accepted medical practices excluding immunizations necessary for international travel. Pediatric immunizations shall include coverage for those child immunizations, including the immunizing agents which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric immunizations are exempt from the Deductible. For purposes of this subsection, child is either the Member and under twenty-one (21) years of age, or the Member's spouse and under twenty-one (21) years of age, or a Family Dependent as defined in Section 6.2 of this Certificate.

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

3.22.5 **Colorectal Screening** which includes fecal occult blood testing, flexible sigmoidoscopy and colonoscopy procedures.

3.22.6 **Additional Preventive Care Services** as specified on the Schedule of Benefits.

3.22.7 **Benefit Limits.** Benefit Limits for preventive services are set forth on the Schedule of Benefits.

3.23 **Pulmonary Rehabilitation.** Outpatient pulmonary rehabilitation is covered for up to thirty-six (36) sessions per Benefit Period.

3.24 Rehabilitative Services. Upon Precertification by the PPO in accordance with Section 2 of this Certificate, physical, occupational and speech therapy, on either an outpatient or inpatient basis, are covered for up to forty-five (45) dates of service per Benefit Period. This forty-five (45) day Benefit Limit is for any combination of physical, occupational and speech therapy Covered Services received within the Benefit Period. The Member should note that if more than one rehabilitative service is received on a particular day, this will only count as one day towards the forty-five (45) day limit.

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

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

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

3.26 Select Injectable Drugs. Subject to the terms and conditions set forth in Section 2 of the Certificate, the following injectable drugs are a Covered Service. Such injectable drugs are subject to the Cost Sharing set forth in Section 3.26.1 and on the Schedule of Benefits.

- Amevive™ (alefacept)
- Aldurazyme™ (laronidase)
- Aralast™ (purified human alpha₁-proteinase inhibitor)
- Aranesp™ (darbepoetin alfa)
- Arranon™ (nelarabine)
- Avastin™ (bevacizumab)
- Boniva™ IV (ibandronate sodium)
- Cerezyme™ (imiglucerase)
- Cimzia™ (certolizumab)
- Eligard™ (leuprolide)
- Epogen™ (epoetin alpha)
- Erbitux™ (cetuximab)
- Fabrazyme™ (agalsidase beta)
- Firmagon™ (degarelix)
- Flolan™ (epoprostenol)
- IVIG™ (intravenous immunoglobulin)
- Ixempra™ (ixabepilone)
- Kepivance™ (palifermin)
- Lucentis™ (ranibizumab)
- Lupron Depot™ (leuprolide acetate)
- Macugen™ (pegaptanib)
- Mozobil™ (pleriafor)
- N-Plate™ (romiplostim)
- Neulasta™ (pegfilgrastim)
- Neupogen™ (filgrastim)
- Ontak™ (denileukin diftitox)
- Orencia™ (abatacept)
- Prialt™ (ziconotide)
- Procrit™ (epoetin alpha)
- Prolastin™ (purified human alpha₁-proteinase inhibitor)
- Reclast™ (zoledronic acid)

- Remicade™ (infliximab)
- Remodulin™ (treprostinil)
- Rituxan™ (rituximab)
- Simponi™ (golimumab)
- Soliris™ (eculizumab)
- Supprelin LA™ (histrelin)
- Synagis™ (palivizumab)
- Torisel™ (temsirolimus)
- Treanda™ (bendamustine)
- Trelstar™ (triptorelin)
- Tysabri™ (natalizumab)
- Velcade™ (bortezomib)
- Viadur™ (leuprolide)
- Visudyne™ (verteporfin)
- Vivaglobin™ (sub q immune globulin)
- Vivitrol™ (naltrexone injection)
- Xolair™ (omalizumab)
- Zemaira™ (purified human alpha₁-proteinase inhibitor)

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

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

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

3.29 **Transplant Services and Authorization Requirements.**

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

- (i) bone marrow (allogeneic and autologous);
- (ii) cornea (does not require Precertification);
- (iii) heart;
- (iv) heart and lung;
- (v) kidney;
- (vi) kidney and pancreas;
- (vii) liver;

- (viii) liver and kidney;
- (ix) lung (single or double);
- (x) pancreas transplant after successful kidney transplant;
- (xi) small bowel; and
- (xii) stem cell.

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

3.29.2 Precertification. All transplant surgery and transplant-related services (with the exception of corneal transplants) require Precertification by the PPO. Medical criteria for any approved transplants will be applied and each potential transplant must be appropriate for the medical condition for which the transplant is proposed. Corneal transplants are covered when Medically Necessary and performed through a Preferred Provider.

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

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

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

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

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

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

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

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

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

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

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

3.29.9 **Retransplantation Services.** Retransplantation surgery and retransplantation-related services require Precertification by the PPO.

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

3.30.1 **Emergency Services.** Transportation services by land or air ambulance is covered when provided in response to an emergency for a condition which meets the definition of Emergency Services as set forth under this Certificate.

3.30.2 **Scheduled Services.** Medically Necessary non-emergency ambulance transportation is covered.

3.31 **Urgent Care.** Urgent Care services received through Preferred Providers in the Service Area are covered. Urgent Care services obtained from a Non-Preferred Provider outside of the Service Area are covered at the Preferred Provider rate when they are provided in response to a sudden and unexpected need for medical care while the Member is outside the Service Area which cannot be deferred until the Member's return to the Service Area.

3.31.1 **Cost Sharing.** The Specialist Copayment shall apply in lieu of the emergency room Copayment when a Member receives Covered Services in a designated Urgent Care facility.

- 3.32 Urological Supplies.** Urinary supplies are covered when the PPO determines the Member has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in the Member within three (3) months.
- 3.33 Voluntary Family Planning Services.** Voluntary family planning services are limited to:
- a) professional services related to the prescribing, fitting and/or insertion of a contraceptive device covered by this Certificate; and
 - b) services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Certificate in Sections 4.17 and 4.28).
- 3.34 Weight Management Program.** The PPO offers a program for weight management that includes education and management on appropriate diet and nutrition, exercise and ongoing monitoring (coaching) to optimize the Member's health status. Weight management program services are covered when provided by the PPO's designated vendors. The Member should contact the Customer Service Team at the telephone number on the back of the Member's Identification Card for specific information on how to access the PPO's designated weight management program vendors.

SECTION 4. EXCLUSIONS

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

- 4.11 Corrective Devices.** The purchase, fitting, or adjustment of corrective devices including but not limited to, eyeglasses, contact lenses, and hearing aids, are **NOT COVERED**.
- 4.12 Cosmetic Surgery.** Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO, is **NOT COVERED**. This exclusion does not apply to Covered Services set forth in Sections 3.14, 3.25.1 and 3.25.2 of this Certificate.
- 4.13 Custodial, Convalescent or Domiciliary Care.** Custodial, Convalescent or Domiciliary Care services are **NOT COVERED**.
- 4.14 Dentistry.** The PPO does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the PPO will cover expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.19.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth) or as may be explicitly provided under the terms of the following Rider: Impacted Wisdom Teeth.
- 4.15 Drug Maintenance Programs.** Drug maintenance programs for the outpatient treatment of drug detoxification, dependency or addiction are **NOT COVERED**. This drug maintenance 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 unless there is an Outpatient Prescription Drug Rider listed on the Schedule of Benefits as being in place with this Certificate. If such a Rider is in place with this Certificate, Suboxone™ and Subutex™ may be administered according to the terms and conditions of the Rider and Certificate Sections 3.16.3 through and including 3.16.3.2, (as applicable) or 3.17.3 through and including 3.17.3.2, (as applicable).
- 4.16 Drugs.** Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in this Certificate at Sections 3.3.3 and 3.29.7 or as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider or an Autism Spectrum Disorder Services Rider if such Riders are listed on the Schedule of Benefits as being in place with this Certificate.
- 4.17 Drugs and Devices for Purposes of Contraception.** Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of an Outpatient Prescription Drug Rider with Contraceptive coverage if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.
- 4.18 Elective Abortions.** Abortions are **NOT COVERED** except for those that are Medically Necessary for the life or physical health of the mother, or to terminate pregnancy caused by rape or incest.
- 4.19 Experimental, Investigational or Unproven Services.** Experimental, Investigational or unproven services are **NOT COVERED**.
- 4.20 Failure to Obtain Precertification.** The following services are **NOT COVERED** when they are obtained from a Non-Preferred Provider prior to Precertification by the PPO:

- 4.20.1 All non-emergency inpatient hospital admissions; and
- 4.20.2 the procedures and services set forth in Section 2.3 of this Certificate, **Designated Procedures and Services Requiring Precertification.**
- 4.21 Foot Care Services.** Except for Members with diabetic conditions, the treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet and chronic foot strain are **NOT COVERED.**
- 4.22 Gender Reassignment.** Transplants, implants, procedures, services and supplies related to gender reassignment are **NOT COVERED.**
- 4.23 Government Responsibility.** Care for military service related disabilities if the care is being provided in a U.S. Military Facility for which the Member does not incur a legal responsibility to pay for such care is **NOT COVERED.**
- 4.24 Government-Sponsored Health Benefits Program.** Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are **NOT COVERED.** All required Precertifications must be obtained even when the PPO is the secondary carrier.
- 4.25 Hair Removal.** Hair removal is **NOT COVERED.**
- 4.26 Hypnosis.** Hypnosis is **NOT COVERED.**
- 4.27 Illegal Activity.** Covered Services required as a result of a Member's commission of or attempt to commit a felony or being engaged in an illegal occupation, are **NOT COVERED.**
- 4.28 Infertility Procedures.** In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), embryo transplants, artificial insemination and similar procedures as determined by the PPO are **NOT COVERED.** Expenses incurred or Covered Services required for any infertility procedures resulting from a Member's or a Member's spouse's voluntary sterilization are **NOT COVERED.** Sperm, ova and embryo storage are **NOT COVERED.**
- 4.29 Insertion and Removal of Non-Covered Implanted Devices.** Any costs, charges or fees associated with the insertion, fitting or removal of an implanted device, when such device is not covered under the terms of this Certificate, are **NOT COVERED.**
- 4.30 Insured Obligations.** Any amounts for a Covered Service which are greater than the PPO's then current Non-Preferred Provider Fee Schedule Amount (except with respect to costs associated with Emergency Services) or which exceed the Lifetime Benefit Maximum set forth on the Schedule of Benefits, or amounts for any Covered Service which are applied toward satisfaction of the Deductible, Copayment or Coinsurance amounts, or which exceed the specific Benefit Limits set forth on the Schedule of Benefits are **NOT COVERED.**
- 4.31 Manipulative Treatment Services.** Manipulative treatment services are services rendered for the treatment or diagnosis of neuromusculoskeletal disorders and are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider: Manipulative Treatment Services.
- 4.32 Mental Health Inpatient Professional Services.** Mental health inpatient professional services provided by a licensed psychiatrist or clinical psychologist are **NOT COVERED** unless expressly set forth in Section 3.21.2 (b) or except as may be explicitly provided under the terms of the following Riders:

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

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

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

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

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

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

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

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

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

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

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

4.41 Panniculectomy, Lipectomy, Liposuction, Abdominoplasty. Excision of excessive skin and subcutaneous tissue including but not limited to panniculectomy, abdominoplasty or lipectomy by any method (such as suction assisted liposuction or aspiration) is **NOT COVERED**. These procedures may involve areas such as, but not limited to, head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks and hips.

- 4.42 Personal Comfort Items/Services.** Personal comfort items and services including but not limited to, telephones, televisions and special meals are **NOT COVERED**.
- 4.43 Prescription Drug Use by a Non-Member.** Use by anyone other than the Member of a Prescription Drug, device or equipment provided to a Member according to the terms and conditions set forth in Section 3, **Covered Services**, of this Certificate or any applicable Riders, is **NOT COVERED**.
- 4.44 Prescription Bandages and Wound Dressings.** Prescription bandages and other wound dressing products are **NOT COVERED** except as may be provided in Section 3.20 of this Certificate.
- 4.45 Private Duty Nursing.** Hourly nursing care on a private duty basis is **NOT COVERED**.
- 4.46 Refraction Examinations.** Examinations to determine the refractive error of the eye are **NOT COVERED** except as may be explicitly provided under the terms of the following Rider: Refractions.
- 4.47 Refractive Procedures.** Any surgery to correct the refractive error of the eye is **NOT COVERED**.
- 4.48 Reversal of Sterilization.** Surgical procedures to reverse voluntary sterilization are **NOT COVERED**.
- 4.49 Revision of the External Ear.** Revision of the external ear is **NOT COVERED**.
- 4.50 Riot or Insurrection.** Covered Services required as a result of a Member's participation in a riot or insurrection, are **NOT COVERED**.
- 4.51 Routine Nail Trimming.** Routine nail trimming is **NOT COVERED**.
- 4.52 Services Provided by a Member's Relative or Self.** Services rendered by a person who is the spouse, child, parent, grandparent, aunt, uncle, niece, nephew or sibling or persons who ordinarily reside in the household of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.
- 4.53 Services Related to or Required by a Non-Covered Service.** Any service related to or required by a non-Covered Service, including but not limited to anesthesia or diagnostic services, is **NOT COVERED**.
- 4.54 Sexual Dysfunction Services, Devices and Equipment.** Sexual dysfunction services, devices and equipment, male or female, are **NOT COVERED**.
- 4.55 Transportation Services.** Stretcher/wheelchair van transportation and transportation services that are not Medically Necessary are **NOT COVERED**.
- 4.56 Vein Sclerosing.** Injection of sclerosing solution into superficial veins (commonly called spider veins) is **NOT COVERED**. Injection of sclerosing solution into varicose leg veins is **NOT COVERED** unless Medically Necessary.
- 4.57 Weight Control.** Weight management programs for non-morbid obesity are **NOT COVERED** except as provided for in Section 3.34 of this Certificate.
- 4.58 THE FOLLOWING SERVICES ARE NOT COVERED WHEN OBTAINED FROM NON-PREFERRED PROVIDERS:**

- 4.58.1 **Diabetic Medical Equipment, Blood Glucose Monitors, Diabetic Foot Orthotics, Insulin and Oral Pharmacological Agents for Controlling Blood Sugar, Disposable Syringes and Blood Glucose Monitor Supplies (Lancets and Blood Glucose Test Strips) and Outpatient Training and Education.** Diabetic medical equipment, blood glucose monitors, foot orthotics, insulin and oral pharmacological agents for controlling blood sugar, disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips) and outpatient training and education are **NOT COVERED**.
- 4.58.2 **Enteral Feedings/Food Supplements.** Enteral feedings/food supplements obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.3 **Foot Care Services.** Foot Care services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.4 **Genetic Counseling and Testing.** Genetic counseling and testing obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.5 **Mental Health or Substance Abuse Services Obtained From a Provider Who Does Not Participate in the PPO's Designated Behavioral Health Benefit Program.** Mental health or Substance Abuse services obtained from a provider who does not participate in the PPO's Designated Behavioral Health Benefit Program are **NOT COVERED**.
- 4.58.6 **Obesity Surgery Performed by Non-Preferred Providers.** Obesity surgery performed by Non-Preferred Providers is **NOT COVERED**.
- 4.58.7 **Organ, Bone Marrow, Stem Cell or Corneal Transplants, Evaluation and Related Services.** Organ, bone marrow, stem cell or corneal transplants, evaluation and related services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.58.8 **Pain Management.** Pain Management services obtained from Non-Preferred Providers are **NOT COVERED**.
- 4.59 **THE FOLLOWING DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC DEVICES AND PROSTHETIC DEVICES ARE NOT COVERED:**
 - 4.59.1 **Access Ramps** for home or automobile are **NOT COVERED**.
 - 4.59.2 **Anodyne Infrared Therapy.** Anodyne infrared therapy is **NOT COVERED**.
 - 4.59.3 **Batteries** for DME, Orthotic Devices and/or Prosthetic Devices are **NOT COVERED**.
 - 4.59.4 **Cold Therapy and/or Ice Packs.** Continuous hypothermia machine cold therapy and/or ice packs are **NOT COVERED**.
 - 4.59.5 **Computerized Devices and Communicative Equipment.** Communicative equipment or devices, computerized assistive devices and communication boards are **NOT COVERED**.
 - 4.59.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** of any sort, except for diabetic foot orthotics which are covered as a Covered Service under Section 3.3.2 of this Certificate, are **NOT COVERED**.

- 4.59.7 **Dental Appliances** of any sort including, but not limited to, bridges, braces and retainers are **NOT COVERED**.
- 4.59.8 **Disposable Supplies** which include but are not limited to, gloves, ace bandages, self-administered catheters, spacer devices for meter dose inhalers, peak flow meters or incentive spirometers are **NOT COVERED**.
- 4.59.9 **Exercise Equipment or Facilities.** Exercise equipment such as whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools and saunas are **NOT COVERED**.
- 4.59.10 **Experimental or Research Equipment** which, as determined by the PPO, is not accepted as Standard medical treatment of the condition being treated, or any such item requiring Federal or other governmental agency approval not granted at the time the Prosthetic Device, Orthotic Device or DME was provided is **NOT COVERED**. The experimental or non-experimental nature of any Prosthetic Device, Orthotic Device, or DME shall be determined by the PPO in accordance with the terms and conditions set forth in Section 1.24 of this Certificate.
- 4.59.11 **Home Monitoring Equipment** is **NOT COVERED**, except for apnea monitors and pulse oximeters which are covered for Members age seventeen (17) and younger.
- 4.59.12 **Items for Personal Comfort or Convenience.** Items which are primarily for personal comfort or convenience, including but not limited to bed boards, air conditioners and over-bed tables are **NOT COVERED**.
- 4.59.13 **More than One Piece of Equipment** that serves the same function, including rental or back up of owned or rented equipment is **NOT COVERED**.
- 4.59.14 **Motor Driven or Deluxe Equipment** of any sort is **NOT COVERED**.
- 4.59.15 **Motor Vehicles or Vehicle Modifications.** Motor vehicles, or any modification to a motor vehicle (including but not limited to car seats) are **NOT COVERED**.
- 4.59.16 **No Longer Medically Necessary.** Any piece of equipment which is determined by the PPO to be no longer Medically Necessary is **NOT COVERED**.
- 4.59.17 **Non-Medical Self-help Devices.** Self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides are **NOT COVERED**.
- 4.59.18 **Non-Preferred Provider.** Unless approved in advance by the PPO, DME, Prosthetic Devices and/or Orthotic Devices which are obtained from a Non-Preferred Provider are **NOT COVERED**.
- 4.59.19 **Non-Standard Equipment or Devices.** Deluxe Equipment or devices of any sort, which has been otherwise determined by the PPO to be non-Standard is **NOT COVERED**.
- 4.59.20 **Repair or Replacement** of any piece of equipment/device, such as for loss, theft or misuse are **NOT COVERED**, except as specifically provided for in Section 3.6.2 of this Certificate.

4.59.21 **Replacement of Component Parts or Modification** of a Standard Prosthetic Device unless incident to the Member's growth for a Member who is under the age of nineteen (19) years as set forth in Section 3.6.4.1 of this Certificate is **NOT COVERED**.

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

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

SECTION 5. APPEAL PROCEDURE

5. **APPEAL PROCEDURE.** Requests for an appeal must be submitted **in writing** and received by the PPO within **one hundred eighty (180) days** following the Member's receipt of the notification of an Adverse Benefit Determination (an Adverse Benefit Determination is any decision made by the PPO with respect to payment or service related issues that results in a denial).

*If a Member chooses to appeal an Adverse Benefit Determination, a **written request** must be submitted to:*

Geisinger Choice PPO
Appeal Department
100 North Academy Avenue
Danville, PA 17822-3220

At any time during any of the appeal processes outlined below, a Member may choose to designate in writing a representative to participate in the appeal process on the Member's behalf (an "Authorized Representative"). In this Section 5 of the Certificate, the definition of Member shall include a Member's Authorized Representative. The Member shall be responsible to notify the PPO in writing of such designation. The PPO has an authorization form available for the Member's use in order to designate an individual to act as the Member's Authorized Representative. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member's Identification Card.

Members have the right to provide the PPO with written comments, documents, records or other information to be considered as part of the appeal review.

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

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

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

Pre-Service Appeal – Not later than 30 days after the PPO receives the written request

Post-Service Appeal – Not later than 60 days after the PPO receives the written request

Urgent Care Appeal – Not later than 72 hours after the PPO receives the request

- 5.1 **Pre-Service Appeal Procedure.** A Pre-Service Appeal is a request to change an Adverse Benefit Determination for care or services that the PPO must approve, in whole or in part, in advance of the Member obtaining care or services.

A Member may request a Pre-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

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

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

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

- a) the basis for the decision in easily understandable language;
- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and
- d) the notification of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

5.2 **Post-Service Appeal Procedure.** A Post-Service Appeal is a request to change an Adverse Benefit Determination for care or services that have already been received by the Member.

A Member may request a Post-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

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

5.2.2 **Post-Service Appeal of any Adverse Benefit Determination.** A Post-Service Appeal of any Adverse Benefit Determination that is based in whole or in part on a

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

5.2.3 Post-Service Appeal Time Frame for Decision. A Post-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than sixty (60) days after receipt of the written request. The PPO shall provide the Member with written notification of the PPO's decision no later than sixty (60) days from receipt. The written notification from the PPO shall include:

- a) the basis for the decision in easily understandable language;
- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and
- d) notification of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

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

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

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

5.3.2 Review of an Urgent Care Appeal. An Urgent Care Appeal will be reviewed by a PPO Medical Director who did not previously participate in any prior decision relating to the appeal and shall not be a subordinate of the person(s) who made the

initial Adverse Benefit Determination. A decision shall be made within seventy-two (72) hours after receipt of the request for an Urgent Care Appeal. The Medical Director will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. The review will include the input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages, treats or consults on the health care service or condition. The PPO shall provide the Member with written notification of the PPO's decision that shall include:

- a) the basis for the decision in easily understandable language;
- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and
- d) notification of the fact that if the Member is a member of an ERISA group, the Member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

SECTION 6. ELIGIBILITY

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

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

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

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

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

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

6.2.1 A dependent child is defined as:

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

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

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

continued coverage of a spouse shall be payable from the date of marriage. No evidence of insurability shall be required.

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

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

An adopted child or a child placed for adoption with the Subscriber is automatically covered under this Policy for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from single to Family Coverage) must be submitted to the PPO within thirty-one (31) days of the date of adoption or date the child was placed for adoption with the Subscriber. The PPO will require documentary proof (i.e., official court documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage. No evidence of insurability shall be required.

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

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

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

In addition, such unmarried dependent child must have been enrolled as a Family Dependent under this Certificate prior to reaching the age of nineteen (19) or under the terms of another Group health benefit program offered by the Group as an alternative to the PPO. The PPO may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the

date on which the PPO is first notified of such disability and dependency, whichever is earlier.

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

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

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

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

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

6.2.7.2 **Continuing Coverage of Full-Time Students on Medical Leave.** Federally enacted Michelle's Law extends coverage to dependent full-time students over the age of eighteen (18) who are enrolled in an institution of higher education and who would otherwise lose health care coverage if a Medically Necessary leave of absence causes them to fall below full-time student status. To continue the student's coverage, the PPO must be provided with a physician's written certification of the student's serious illness or accident citing the Medical Necessity of the leave. Such coverage will be provided by the PPO for: a) up to one year after the first day of the leave of absence or b) the date the student's

coverage would otherwise terminate under the terms and conditions of the Certificate; whichever date comes earlier. Under Michelle's Law regulations, the student will receive the same coverage as the Subscriber and other Family Dependents under the Certificate.

6.2.8 Noncustodial Children. A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order. The Subscriber must make written application for membership of such child. The PPO will require documentary proof (i.e., official court order) evidencing the obligation of the Subscriber to provide health care coverage. Coverage shall be effective within thirty (30) days of receipt by the Plan of said official court order. The Subscriber shall notify the PPO of the name and address of the custodial parent in order to allow the PPO to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania. The PPO may not disenroll or eliminate coverage of any child unless the PPO is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

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

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

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

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

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

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

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

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

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

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

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

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

b) the Subscriber on behalf of himself and/or any Family Dependents.

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

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

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

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

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

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

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

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

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

6.8 Failure to Enroll Or Be Enrolled When Eligible. Any eligible individual who fails to enroll or be enrolled during an Open Enrollment Period or within thirty-one (31) days after

first becoming eligible shall not be permitted to enroll until the next Open Enrollment Period unless they meet the rules for Special Enrollment Periods.

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

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

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

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

6.9 Pre-Existing Condition Exclusion. Coverage for Pre-Existing Conditions shall begin after the Member has been covered under the PPO for twelve (12) months. This exclusion applies to all services, with the exception of those set forth in this Certificate. The Pre-Existing Condition exclusion shall begin from the date of enrollment under the Certificate and credit shall be given for the time the Member had Creditable Coverage as set forth in Section 6.8.2. To the extent that this Certificate replaces another group contract, the PPO shall only apply a Pre-Existing Condition exclusion if excluded by the other group policy.

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

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

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

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

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

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

SECTION 7. PAYMENT PROVISIONS

7. PAYMENT PROVISIONS.

- 7.1 Payment of Premiums.** The monthly premiums for coverage are specified in the Group Master Policy, as amended from time to time. The Group or its agent on behalf of a Subscriber shall make payment of such premium for coverage under this Certificate. Premium shall be remitted on a monthly basis to the PPO within the specified time frames set forth in this Certificate or as otherwise set forth in the Group Master Policy. Only a Member for whom the premium is actually received by the PPO shall be entitled to coverage under this Certificate and only for the month for which such premium is received.
- 7.2 Adjustment of Premiums.** The monthly premiums shall be effective until the renewal date of the Group Master Policy and shall be subject to revision thereafter as of each renewal date of the Group Master Policy, or such other date as the Group and the PPO may specify. The PPO will notify the Group of any adjustment to premium as set forth in the Group Master Policy. Notice of adjustment of a premium, or adjustment of the Subscriber's contribution to the premium as required by the Group, will be provided by the Group to the Subscriber. Premium changes may be subject to review and approval by the Pennsylvania Department of Insurance.
- 7.3 Time of Payment.** In order for benefits to be provided, the premium must be paid on or before the first day of the effective coverage month for each Member under this Certificate or as specified in the Group Master Policy, subject to the grace period provisions specified in this Certificate. The first monthly premium must be paid in full on or before the due date indicated on the first premium statement.
- 7.4 Grace Period.** If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within thirty (30) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 8.6 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 8.9. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependent during the grace period.

SECTION 8. GENERAL PROVISIONS

8. GENERAL PROVISIONS.

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

8.2 Coordination of Benefits.

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

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

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

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

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

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

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

8.2.2 **Applicability.**

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

8.2.3 **Order of Benefit Determination Rules.**

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

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

8.2.4 Effect on the Benefits of This Plan.

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

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

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

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

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

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

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

TERM AND TERMINATION.

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

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

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

8.6.1 Failure to Pay.

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

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

8.6.2 Fraud or Material Misrepresentation.

8.6.2.1 By the Group. In the event the Group makes an intentional misrepresentation for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. This decision may be appealed through the PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

8.6.2.2 By the Member. If it is proven that the Member attempted or committed fraud under this Certificate to obtain benefits or payment or if the Member makes an intentional misrepresentation of material fact in the application for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber and the Group. This decision may be appealed through

the PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

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

- 8.6.3 **Failure to Continue to Meet the Group Eligibility Requirements.** If a Member ceases to meet the Group eligibility requirements, coverage shall terminate subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber.
- 8.6.4 **Termination of Group Master Policy.** The PPO may terminate the Group Master Policy in accordance with the provisions of that agreement. Termination of the Group Master Policy by the PPO means that individual rights to benefits and Covered Services awarded under this Certificate cease on the effective date of termination. If a Member whose coverage was terminated pursuant to this Section has succeeding or alternate carrier health service coverage, they are not eligible for conversion to individual, direct payment coverage where there is a succeeding or alternate carrier. In the event of termination of the Group Master Policy, the Member shall, however, still be eligible for continuation of benefits set forth in Section 8.9 of this Certificate.
- 8.6.5 **Subscriber's Death.** In the event of the death of a Subscriber, coverage shall terminate for his enrolled Family Dependents on the last day of the period for which payments have been made by, or on behalf of such Subscriber, subject to the conversion privilege set forth below. Surviving Family Dependents may also be eligible to continue Group coverage under the provisions of COBRA (for COBRA-eligible Groups) and under Section 8.9 of this Certificate.
- 8.6.6 **Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings.** Any adoption, Legal Guardianship or Legal Custodianship that fails or is abandoned will result in termination of coverage with respect to the child subject to fifteen (15) days written notice by the PPO to the Group and the Subscriber. This decision may be appealed through the PPO established appeal procedure as set forth in Section 5 of this Certificate.
- 8.6.7 **Disruptive Behavior.** The PPO may terminate a Member's coverage for cause if the Member's behavior is disruptive, unruly, abusive or uncooperative to the extent that his continuing membership in the PPO seriously impairs the PPO's ability to provide Covered Services to either that Member or to other Members. Termination will occur after the PPO has made a reasonable effort to resolve the problem presented by the Member, including encouraging the Member to utilize the PPO's internal appeal procedure as set forth in Section 5 of this Certificate.
- 8.6.8 **Conversion Privileges.** If a Member's coverage terminates for any reason other than non-payment of a required contribution and the Member has been continuously insured under the Certificate for at least three (3) months immediately prior to termination, the Member shall be eligible for individual conversion coverage (referred to as "Conversion Coverage").

A Member is not entitled to Conversion Coverage if other similar group coverage will replace this Certificate within thirty-one (31) days, or if coverage terminated under the Certificate because the Member failed to pay required premium contributions. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA and Mini-COBRA eligible

Groups) are eligible for conversion coverage when their COBRA eligibility for Group coverage expires

The PPO will give the Member written notice of the conversion privilege within fifteen (15) days before or after the date of termination of coverage. The Member must apply for Conversion Coverage and pay the applicable premiums within thirty-one (31) days after the termination of coverage under the Certificate, or within fifteen (15) days after the PPO provides the Member notice of conversion rights, whichever is later.

The Member may enroll in Conversion Coverage without a medical examination. The first premium payment must be received before Conversion Coverage will be put in force. Conversion Coverage shall begin the day after termination of coverage under the Certificate.

8.7 Reinstatement.

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

8.7.2 At its sole discretion, the PPO may reinstate a Member whose coverage has been terminated:

- a) for loss of eligibility, if the Member recaptures eligibility status and continues to satisfy the eligibility requirements; or
- b) at the Subscriber's request, if the Subscriber or the Group notifies the PPO within thirty-one (31) days of the date of the initial request to terminate that termination is no longer desired.

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

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

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

whichever comes first.

In the event coverage terminates because of active employment termination, the Covered Services will be provided for twelve (12) months during total disability with respect to the sickness or injury which caused the disability for twelve (12) months, unless coverage is afforded for total disability under another group plan.

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

MISCELLANEOUS.

- 8.11 Disclaimer of Liability.** It is expressly understood that the PPO (as a corporation or otherwise) does not furnish any health service benefits. The PPO contracts with professional providers of care for the Covered Services received by Members under this Certificate. The PPO's obligation is limited to furnishing Covered Services through contracts with such providers of care. The PPO (as a corporation or otherwise) is not, in any event, liable for any act or omission of the professional personnel of any medical group, hospital, or other provider of services.
- 8.12 Designation of an Authorized Representative.** Members have the right to designate an authorized representative who, in addition to the Member receiving services, will receive Explanation of Benefits forms from the PPO. If a Member wishes to designate an authorized representative, they must complete and sign an Authorized Representative form. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member Identification Card.
- 8.13 Refusal to Accept Recommended Treatment and Advance Health Care Directives.** A Member has the right to participate in planning his own treatment and to give his informed consent before the start of any procedure or treatment. A Member also has the right to formulate an Advance Health Care Directive and/or appoint a surrogate to make health care decisions on his behalf to the extent permitted by law, should the Member become incapacitated. Any Member may, for personal reasons, refuse to accept one or more drugs, treatments or procedures recommended by a Preferred Provider. A Member has the option to refuse to accept the recommended drug, treatment or procedure of a Preferred Provider, either:
- a) verbally;
 - b) through an Advance Health Care Directive; or
 - c) through a properly appointed surrogate.
- 8.14 Claims and Reimbursement.**
- 8.14.1 Claims.** The PPO will not be liable under this Certificate unless proper notice is furnished to the PPO that Covered Services have been rendered to a Member as follows:
- a.) **Preferred Provider Claims.** The timely filing of claims is the responsibility of the Preferred Provider, and the Member will have no payment responsibility for such claim which is not filed on a timely basis by the Preferred Provider.
 - b.) **Non-Preferred Provider Claims.** Members are required to file a claim for all services rendered by a Non-Preferred Provider. No payment will be made for any claims filed by a Member for services rendered by a Non-Preferred Provider unless the Member gives written notice of such claim to the PPO within one (1) year of the date of service.

To file a claim, the Member should call the PPO at the telephone number listed on the Member Identification Card to obtain a claim form. Section A of the claim form must be signed by the Member before the PPO will issue payment to a provider or

reimburse the Member for services received under this Certificate. The Member must complete a claim form for services rendered by a Non-Preferred Provider and submit it, together with an itemized bill, to the following address:

Geisinger Quality Options, Inc.
P.O. Box 8200
Danville, PA 17821-8200

If a claim form is not received by the Member within fifteen (15) days of request to the PPO, the Member may provide an itemized bill from the Provider containing the following information, in writing, in lieu of the claim form:

- 1.) Full name of Member for whom the services were rendered.
- 2.) Date(s) of service.
- 3.) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
 - a. Procedure/Service codes (and Modifiers)
 - b. Diagnosis codes
 - c. Location code
- 4.) Charges for each service.
- 5.) Servicing Provider/facility and address. If available, telephone number and Provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Quality Options, Inc.
P.O. Box 8200
Danville, PA 17821-8200

Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof of loss is otherwise required.

8.14.2 Reimbursement. In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, the PPO will reimburse the Member by check immediately upon receipt of written proof of claim set forth under Section 8.14.1 of this Certificate. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the PPO as soon as possible, but in no event later than one (1) year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

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

8.16 Authorization to Disclose Confidential Information. Subject to the medical records confidentiality provisions below, the PPO is entitled to receive from any provider of Covered Services to any Member, information reasonably necessary in connection with the administration of this Certificate.

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

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

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

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

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

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

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

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

Geisinger Quality Options, Inc.
M.C. 3220
100 North Academy Avenue

Danville, PA 17822
Attention: Administration

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

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

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

EXHIBIT 1
GEISINGER CHOICE PPO WITH NO REFERRAL
SERVICE AREA

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

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

BEDFORD COUNTY

- the following zip codes only:

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

ELK COUNTY

- the following zip codes only:

15821
15822
15823
15827
15831
15841
15846
15860
15868

EXHIBIT 2

Non-Preferred Provider Cost Sharing Example Chart

As described in Section 1.17, when using a Non-Preferred Provider, any costs that exceed the PPO's Non-Preferred Provider Fee Schedule are not included in the DCC Maximum. This means that the Member will be financially responsible for the difference between the PPO's Non-Preferred Provider Fee Schedule and the Non-Preferred Provider's billed charge, even if the DCC Maximum has been reached. This could result in significant financial liability for the Member.

The following example illustrates the concept outlined above:

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

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

Amendment to Non-Grandfathered Group Benefit Document

**GEISINGER CHOICE PPO WITH NO REFERRAL
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN
("QHDHP")**

Identified as the

GEISINGER ALL-ACCESS QHDHP PPO

GEISINGER QUALITY OPTIONS, INC.

A Pennsylvania corporation located at:

100 North Academy Avenue

Danville, Pennsylvania 17822

GEISINGER QUALITY OPTIONS, INC.

A Pennsylvania corporation located at:
100 North Academy Avenue
Danville, Pennsylvania 17822

Dear Subscriber:

Thank you for choosing a Geisinger All-Access QHDHP PPO product. This product provides a comprehensive major medical program of inpatient and outpatient facility and Provider benefits. Benefits are subject to the medical management and pharmacy procedures and Precertification process provisions with possible loss of benefits for non-compliance.

This document amends your Subscription Certificate by adding, deleting and revising certain provisions. It would be advisable to reference your Subscription Certificate as you review the revisions detailed in this Amendment as the changes affect the benefits provided to you in your Subscription Certificate. Some of the benefits in this Amendment are those set forth in the Patient Protection and Affordable Care Act ("PPACA") of 2010 (commonly known as Health Care Reform). However, this Amendment also contains other non-PPACA changes to your benefit documents.

Please keep this Amendment handy for easy reference. If you have any questions about the Amendment revisions, our Customer Service Team will be happy to help. Call them at the number listed on the back of your Member Identification Card.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Gaskill", written in a cursive style.

Jeremy Gaskill
President

100 North Academy Avenue • Danville, PA 17822-3226

Discrimination is against the law

Geisinger Quality Options, Inc., complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity and sex stereotypes). Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Geisinger Quality Options, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, call Geisinger Health Plan at 800-447-4000 or TTY: 711.

If you believe that Geisinger Quality Options, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 N. Academy Ave., Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
ghpcivilrights@thehealthplan.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the civil rights grievance coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-447-4000 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-447-4000 (TTY: 711) o hable con su proveedor.

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-447-4000 (TTY: 711) 或與您的提供者討論。

אכטונג: אויב איר רעדט אידיש, זענען דא אומזיסטע שפראך הילף סערוויסעס וואס קענען צוגעשטעלט ווערן פאר אייך. נויטיגע צוגאבליכע הילף און סערוויסעס כדי צו צושטעלן אינפארמאציע אין א צוגענגליכע פארמאטן ווערן אויך צוגעשטעלט פריי פון אפצאל. רופט 1-800-447-4000 (TTY: 711) אדער רעדט צו אייער פראוויידער.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-447-4000 (TTY: 711) или обратитесь к своему поставщику услуг.

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주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-447-4000 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-447-4000 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-447-4000 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-447-4000 (TTY: 711) મા ફોન ગર્નુહોસ્ વા આપનો પ્રદાયકસંગ કુરા ગર્નુહોસ્।
AKIYESI: Ti o ba so Yorùbá, awon ise iranlowo ede ofe wa fun o. Awon iranlowo iranlowo ti o ye ati awon ise lati pese alaye ni awon ona kika wiwole tun wa laisi idiyele. Pe 1-800-447-4000 (TTY: 711) tabi soro si olupese re.
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրվում համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Չանգահարեք 1-800-447-4000 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ:

GEISINGER QUALITY OPTIONS, INC.

AMENDMENT TO THE

QHDHP PPO GROUP SUBSCRIPTION CERTIFICATE

The **GEISINGER QUALITY OPTIONS INC., PPO GROUP SUBSCRIPTION CERTIFICATE (“Certificate”)** (Form M-151-444-F Rev. 4/10) to which this Amendment is attached, is revised as follows:

1. **MARKETING NAME OF CERTIFICATE** – The marketing name of this Certificate shall hereby be revised from “Geisinger Choice PPO with No Referral Qualified High Deductible Health Plan” to “Geisinger All-Access QHDHP PPO”.

All references to the Certificate’s marketing name which may appear in the Certificate, Amendments, the Schedule of Benefits, the enrollment applications and the Member’s Enrollment Letter are hereby correspondingly revised.

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

3. **SECTION 1. DEFINITIONS.**

- A. Section 1, General Definitions, shall be updated as follows:

1. **GENERAL DEFINITIONS.** The following terms, when used in this Certificate and all applicable Amendments, Riders and Schedule of Benefits will have the meanings assigned to them below unless these terms are otherwise defined by the PPO or its designated agent in such other applicable documents (please note that these terms will be capitalized when used in document text):

- B. Section 1.5, **Benefit Period**, is deleted in its entirety and replaced with the following:

- 1.5 **Benefit Period** means the period of time this Certificate is in effect as indicated on the Schedule of Benefits. A Member’s Benefit Period shall begin on the Effective Date as noted on the Schedule of Benefits.

- C. Section 1.13, the definition of “**Creditable Coverage**”, and all references to “Creditable Coverage” are deleted from the Certificate.

- D. Section 1.16, **Deductible**, is deleted in its entirety and replaced with the following:

- 1.16 **Deductible** means a specified dollar amount as set forth on the Schedule of Benefits for the cost of Covered Services that must be incurred and paid by a Member or Family Unit before the PPO will assume any liability for all or part of the cost of Covered Services. The Deductible applies to each Member subject to any Family Deductible set forth on the Schedule of Benefits. Distinct Deductible amounts apply to Covered Services obtained from either Preferred or Non-Preferred Providers, as set forth on the Schedule of Benefits. Amounts paid toward satisfaction of the Deductible amounts for Covered Services obtained from either Non-Preferred Providers or Preferred Providers do not accrue toward each other.

In addition, certain Supplemental Health Services may have a separate Deductible as set forth on the Schedule of Benefits and the terms of the applicable Rider. Deductible amounts must be met every Coverage Period before the corresponding Coinsurance or Copayment amount applies. Deductible amounts accrue toward satisfaction of any Maximum Out-of-Pocket amount. Copayment amounts do not accrue towards satisfaction of any Deductible amounts.

- E. Section **1.17**, the definition of **Deductible, Coinsurance and Copayment Maximum (“DCC Maximum”)** and all references to “DCC Maximum” are deleted from the Certificate and replaced with the term, Maximum Out-of-Pocket.
- F. Section **1.18**, the definition of **Designated Behavioral Health Benefit Program**, and all references to “Designated Behavioral Health Benefit Program” are deleted from the Certificate.
- G. Section **1.24, Experimental, Investigational or Unproven Services**, Subsection “b” is deleted in its entirety and replaced with the following:
 - b) the subject of an ongoing clinical trial that meets the definition of a Phase I, II, III or IV clinical trial set forth in the FDA regulation. Procedures and services provided as being related to an investigational technology, or rendered as part of a clinical trial or research protocol, including but not limited to, services and procedures that would otherwise be covered, and hospital admissions solely for the purpose of providing an investigational technology, research protocol or clinical trials are NOT COVERED, regardless of whether the trial is subject to FDA oversight; or
- H. Section **1.28, Group**, is deleted in its entirety and replaced with the following:

1.28 Group means the employer, union or trust through which the Subscriber is enrolled and who agrees to remit premiums for coverage payable to the PPO. The Group is identified on the Schedule of Benefits.
- I. Section **1.31, Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, is deleted in its entirety and replaced with the following:

1.31 Health Insurance Portability and Accountability Act of 1996 (HIPAA) as may be amended from time to time, is a federal law including, but not limited to, the following:

 - a) prohibiting discrimination against employees and dependents based on their health status; and
 - b) regulating the use and disclosure of protected health information.
- J. Section **1.32.3, Hospice**, is deleted in its entirety and replaced with the following:

1.32.3 Hospice means a Covered Service rendered by a Provider who is licensed as a provider of Hospice services in the Commonwealth of Pennsylvania and is a certified provider of Hospice services under Medicare.
- K. Section **1.42, Member**, is deleted in its entirety and replaced with the following:

1.42 Member means an individual eligible to receive Covered Services or benefits under the terms of this Certificate either as the Subscriber; or an individual who is:

 - 1) a newborn child, whether natural born, adopted, or placed for adoption, for thirty-one (31) days from the date of birth; and/or
 - 2) an eligible enrolled Family Dependent, (except as defined under Sections 5, to include a Member’s representative and Section 8 for Coordination of Benefit purposes).

- L.** The definition of **Precertification**, (**Section 1.48**), is deleted from the Certificate and replaced with the following:

1.48 Precertification means the process detailed in Section 2.3.1 of this Certificate whereby all non-emergency inpatient hospital admissions or certain designated procedures and services as listed in Exhibit 3, Precertification List, are reviewed by the PPO or its designated agent for coverage determination based on Medical Necessity prior to the provision of services.

- M.** The definition of **Pre-Existing Condition**, (**Section 1.49**), is deleted from the Certificate.

- N.** Section **1.66, Urgent Care**, is deleted in its entirety and replaced with the following:

1.66 Urgent Care means any Covered Service provided to a Member in a situation which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency Service as it allows the Member to consider alternative settings of care. If the Member is out of the Service Area and needs Urgent Care, to be covered, the care must be in response to a sudden and unexpected condition or injury that needs care which cannot be put off until the Member returns to the Service Area.

- O.** The definition, **Mini-COBRA**, is added to the Certificate as follows:

Mini-COBRA means the continuation coverage, as may be amended from time to time, enacted by the Commonwealth of Pennsylvania for Members in a Mini-COBRA eligible Group of two (2) to nineteen (19) employees who incur certain qualifying events (as defined under Mini-COBRA).

- P.** The definition, **Provider**, is added to the Certificate as follows:

Provider shall mean Health Care Provider.

- Q.** The definition, **Maximum Out-of-Pocket**, is added to the Certificate as follows:

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

- (i) amounts above a specific Benefit Limit as set forth in the Certificate and/or Schedule of Benefits;
- (ii) amounts above the PPO's Non-Preferred Provider Fee Schedule Amount;
- (iii) amounts for non-Covered Services; and
- (iv) amounts for Covered Services obtained from a Non-Preferred Provider (as applicable).

This means that the Subscriber or Member, not the PPO, will be responsible for payment of all the amounts noted above, even if the Maximum Out-of-Pocket has been reached. As item (ii) can result in substantial financial responsibility for the Subscriber or Member, please refer to Exhibit 2 of this Certificate for an illustration of potential Cost Sharing when Non-Preferred Providers are utilized. Please note that, as applicable, there are separate Maximum Out-of-Pocket amounts for Preferred and Non-Preferred Providers. Maximum Out-of-Pocket amounts paid for Covered Services provided by either a Preferred Provider or a Non-Preferred Provider do not accrue towards each other. The Maximum Out-of-Pocket applies to each Member or Family Unit subject to any family Maximum Out-of-Pocket set forth on the Schedule of Benefits.

- R.** The definition, **Telehealth**, is added to the Certificate as follows:

Telehealth means remote clinical services and remote non-clinical services.

- S.** The following definitions are added to the Certificate as follows:

Geisinger Coverage Network (“Coverage Network”) means the Health Care Providers who have entered into a written agreement with the PPO to provide Covered Services to Members as part of the PPO’s panel of Preferred Providers located in the Service Area (Exhibit 1A) plus the following counties identified on Exhibit 1B, as such counties may be amended from time to time. The Geisinger Coverage Network also includes the Providers identified on Exhibit 1C, as such Providers may be amended from time to time. The Geisinger Coverage Network does not include professionals and facilities in the Geisinger Extended Coverage Network.

Geisinger Extended Coverage Network (“Extended Network”) means the Health Care Providers located outside of the Geisinger Coverage Network and accessed through the Cigna Healthcare® PPO Network to provide Covered Services to Members. These Extended Network Health Care Providers are Non-Preferred Providers within the Service Area of the Coverage Network and the counties identified on Exhibit 1B, as such counties may be amended from time to time. For a list of the Health Care Providers in the Extended Network please refer to www.Geisinger.org/health-plan.

T. **Section 1.43, Network**, is deleted in its entirety and replaced with the following:

1.43 Network means the Health Care Providers who have entered into a written agreement with the PPO to provide Covered Services to Members as part of the PPO’s panel of Preferred Providers. Network includes the Geisinger Coverage Network and the Geisinger Extended Coverage Network.

U. **Section 1.44, Non-Preferred Provider**, is deleted in its entirety and replaced with the following:

1.44 Non-Preferred Provider means a Health Care Provider or Provider that does not have an agreement with the PPO to provide Covered Services to the PPO’s Members.

V. **Section 1.51, Preferred Provider or Preferred Health Care Provider**, is deleted in its entirety and replaced with the following:

1.51 Preferred Provider or Preferred Health Care Provider means a Health Care Provider that has an agreement with the PPO pursuant to which negotiated rates are established on a Preferred Provider basis for payment of Covered Services to Members under this Certificate and pursuant to which such Health Care Provider is a part of the PPO’s Network. For the Geisinger Extended Network, the PPO contracts with the Cigna Healthcare® PPO Network, a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member’s Identification Card for a listing of Preferred Providers.

W. The following definitions are added to the Certificate as follows:

Sex-trait Modification Procedure(s) means any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual’s physical appearance or body with an asserted identity that differs from the individual’s sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual’s physical appearance or body, including amputating, minimizing, or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual’s physical appearance or body with an asserted identity that differs from the individual’s sex.

Mental health services will continue to be covered as an essential health benefit as required by section 1302(b)(1)(E) of the Affordable Care Act, including for those who seek or undergo specified sex-trait modification procedures or are diagnosed with gender dysphoria.

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

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

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

Substance Use Disorder means any use of drugs and/or alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

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

4. SECTION 2. MEDICAL MANAGEMENT PROCEDURES AND PRECERTIFICATION PROCESS.

- A. Section 2.1, **Medical Management Procedures**, is deleted from the Certificate and replaced with the following:

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

- a) Urgent/Emergent admission to a Non-Preferred Provider will be managed through the PPO's out-of-Network process. The Member may be offered transfer to a facility Preferred Provider when determined appropriate by the PPO.
- b) Planned inpatient admissions and certain designated services and procedures require Precertification.
- c) The PPO's clinical staff is available to assist Members who require transplants, have catastrophic disease or injury, are temporarily outside the Service Area and require Urgent Care or can benefit from individualized attention to coordinate their needs.
- d) The PPO's medical management staff coordinates with the quality improvement staff to collect data and review issues to assure appropriate care in the most efficient manner.
- e) Concurrent review (a review of the Member's care while under an ongoing course of treatment) may be required for services such as, but not limited to, inpatient admissions, (including emergencies and admissions where the PPO is not the primary payor), home health care and outpatient rehabilitation. Concurrent review is the responsibility of the facility, not the Member.
- f) A PPO Medical Director will be involved in any decision to deny coverage on the basis of Medical Necessity.

- g) The PPO's medical management policies and procedures comply with all National Committee for Quality Assurance standards and applicable state and federal regulations regarding medical management and utilization.
- h) Covered Services are subject to the terms and conditions of a Member's health benefit plan including any limitation of services and approved based on qualities or attributes which are determined by the PPO or its designated agent to be: (i) Medically Necessary; (ii) representative of the customary and routine treatment requirements of the Member; and (iii) readily available. The PPO's Medical Management staff utilizes nationally recognized, evidenced based criteria, as well as internally developed Medical Benefit Policies to determine Medical Necessity and appropriate levels of care. In the absence of criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations.

B. Section **2.2, Precertification**, is deleted from the Certificate and replaced with the following:

2.2 Precertification. The purpose of Precertification is to determine Medical Necessity and to encourage and facilitate the use of the most appropriate level of care utilizing objective and evidence-based criteria taking individual circumstances and the local delivery system into account. In the absence of criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations. Alternate treatment settings may be recommended for approved procedures if inpatient hospitalization is deemed unnecessary. Precertification does not verify a Member's coverage by the PPO or guarantee payment. Precertification is required even when the PPO is not the primary carrier.

C. Section **2.3, Designated Procedures and Services Requiring Precertification**, and subsections 2.3.1, 2.3.2 and 2.3.3 are deleted from the Certificate and replaced with the following:

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

Please refer to **Exhibit 3** of this Certificate for a list of services, supplies, agents/medications which require Precertification.

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

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

- d) Written notification of approval or denial of the proposed services will be provided to (i) the Member and the Preferred Provider or (ii) the Member and the Non-Preferred Provider, as applicable, within the time frames required by applicable law. **PLEASE NOTE THAT THE PRECERTIFICATION PROCESS HAS NOT BEEN COMPLETED IF A NOTIFICATION LETTER HAS NOT BEEN RECEIVED BY THE MEMBER.**

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

- 2.3.2 **Ultimate Responsibility for Precertification When the Member Chooses to Utilize a Non-Preferred Provider.** Although a Non-Preferred Provider may contact the PPO or its designated agent for Precertification on the Member's behalf, **it is ultimately the responsibility of the Member to ensure that Precertification occurs prior to the date of service when the Member chooses a Non-Preferred Provider for the services and procedures set forth in this Section.**

- 2.3.3 **Failure to Precertify.** All services and procedures identified in this Section which are rendered by a Non-Preferred Provider and which **REQUIRE** Precertification are **NOT COVERED** when Precertification is not obtained.

5. SECTION 3. COVERED SERVICES.

- A. Section **3.1.1, Covered Services from a Non-Preferred Provider**, Subsection **3.1.1 (c)** is deleted from the Certificate and replaced with the following:

c) when Covered Services are not available from a Preferred Provider; or

- B. Section **3.1.2, The PPO's Coverage of Covered Services**, is deleted from the Certificate and replaced with the following. Subsections **3.1.2.2, Covered Services Obtained Outside the Service Area**, and **3.1.2.3 Maternity care outside the Service Area**, are deleted from the Certificate in their entirety:

3.1.2 The PPO's Coverage of Covered Services:

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

If you are in the Service Area or the counties identified on Exhibit 1B, as such counties may be amended from time to time, only Covered Services rendered by Preferred Providers in the Geisinger Coverage Network are covered at the Preferred Provider rate.

Covered Services rendered by Preferred Providers in the Geisinger Extended Network are covered at the Preferred Provider Rate.

Covered Services rendered by Non-Preferred Providers are covered at the Non-Preferred Provider rate.

- C. Section **3.1.3, Covered Service Location Cost Sharing**, is deleted from the Certificate and replaced with the following:

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

- D. Section 3.2, Cardiac Rehabilitation,** is deleted from the Certificate and replaced with the following:
- 3.2 Cardiac Rehabilitation.** Outpatient cardiac rehabilitation is covered subject to the Benefit Limit and Cost Sharing set forth on the Schedule of Benefits.
- E. Section 3.3.4, Outpatient Training and Education,** the introductory paragraph is amended as follows:
- “Diabetes outpatient self-management training and education, including medical nutrition therapy, shall be covered when provided under the supervision of a Preferred Provider with expertise in diabetes to ensure that Members with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. This shall include visits.”
- Sections i, ii, iii and 3.3.4.1, **Cost-Sharing**, shall remain as written in the Certificate.
- F. Section 3.3.5, Diabetic Eye Examinations,** is added to the Certificate as follows:
- 3.3.5 Diabetic Eye Examinations.** The PPO will cover diabetic eye examinations when provided by a Preferred Provider. A Diabetic eye examination does not include a refraction of the eye(s).
- G. Section 3.6, Durable Medical Equipment (DME), Orthotic Devices and Prosthetic Devices,** is amended as follows:
- 1. Section 3.6.1 (d)** which defines the term “Standard” is deleted from the Certificate. Use of the defined term is correspondingly deleted throughout the Certificate.
 - 2. Section 3.6.1 (d)** is now added to the Certificate as follows:
 - d) Rehabilitative Devices** are devices which meet the needs of individuals with disabilities and address the barriers confronted by such individuals. Rehabilitative Devices may address needs in the areas of education, rehabilitation, employment, transportation, and independent living. Rehabilitative Devices include only those devices or services required to overcome the functional limitations imposed by an individual's disability. Examples of Rehabilitative Devices include but are not limited to a speaking board or other communication device for a Member who cannot speak and self-care/home management training such as ADL (Activities of Daily Living) and compensatory training/instructions in the use of adaptive equipment.
- Rehabilitative Devices do not include:
- i)** Devices or services which are considered restoration devices or services. Restoration devices and services are those available under a prescription from a qualified Health Care Provider and/or are available through Medicaid or third party medical insurance (examples include but are not limited to prosthetic and orthotic devices, wheelchairs and hearing aids).
 - ii)** Devices or services which are considered equipment. Equipment devices or services are those required solely for training or employment and are not required as a result of the individual's disability.
 - 3. Section 3.6.4, Prosthetic Devices, Section 3.6.4.1, Members under Age Nineteen (19), and Section 3.6.4.2, Manufacturer,** are deleted from the Certificate and replaced with the following:
- 3.6.4 Prosthetic Devices.** The PPO will pay for the purchase of one (1) Prosthetic Device or the replacement of component parts or modification of an existing Prosthetic Device every five (5) years when obtained from a Preferred Provider subject to the Exclusions set forth in Section

4.59.21 of this Certificate. However, the following Covered Services are not subject to the five (5) year Benefit Limit set forth above:

- (a) initial and subsequent Prosthetic Devices following a mastectomy to replace the removed breast or portions thereof; and
- (b) contact lenses, including gas-permeable rigid contact lenses (known as RGP or GP lenses), for the treatment of progressive eye diseases, including but not limited to keratoconus.

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

3.6.4.2 **Manufacturer.** The PPO reserves the right to restrict the manufacturer of Prosthetic Devices covered under this Certificate. Such restriction is subject to change by the PPO without the consent or concurrence of the Member, except as provided for herein.

H. Section 3.7.3, Emergency Services Protocol, Cost Sharing, is deleted from the Certificate and replaced with the following:

3.7.3 Cost Sharing. Emergency Services are subject to the emergency room Cost Sharing specified on the Schedule of Benefits. The Cost Sharing will be waived if Emergency Services rendered in the emergency department of an acute care hospital result in the immediate admission of the Member to the hospital as an inpatient and the requirements for Emergency Services are satisfied.

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

I. Section 3.8, Enteral Feeding/Food Supplements, is deleted from the Certificate in its entirety and replaced with the following:

3.8 Medical Foods

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

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

J. Section 3.10, Home Health Care, is deleted from the Certificate and replaced with the following:

3.10 Home Health Care. Upon Precertification, home health care is covered. This Section does not apply to home health care services for follow-up maternity care for early discharge which is set forth at Section 3.15 of this Certificate.

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

3.10.1 Skilled Nursing Personnel. Skilled nursing visits in the home that are provided by skilled nursing personnel who are supervised by physician Providers are covered subject to Precertification.

3.10.2 Physician Services. When the nature of the illness dictates, care in the home by a physician is covered.

3.10.3 Other Health Care Personnel. Medical care in the home is covered when the care is given by Health Care Providers (including but not limited to, speech, physical and occupational therapists) under the supervision of a physician Provider. This care is covered, subject to Precertification and any specific benefit limitations set forth in this Section 3 of the Certificate.

3.10.4 Follow-Up Care Post-Mastectomy Surgery. One (1) home health visit after discharge of mastectomy surgery is covered provided that the discharge occurs within forty-eight (48) hours of admission for mastectomy surgery.

K. Sections **3.11, Hospice, 3.11.1, Hospice Benefit Election, and 3.11.2, Limitations,** are deleted from the Certificate and replaced with the following:

3.11 Hospice. The following services for Hospice are covered: Routine Home Care, Continuous Care, General Inpatient Care, and Respite Care, as well as those Hospice services noted in this Certificate, provided such care is directly related to the Terminal Illness of a Member and rendered in accordance with the Member's Plan of Care.

3.11.1 Hospice Benefit Election. The Member shall have the option to elect to receive Hospice benefits as set forth in this Certificate. By electing to receive the Hospice benefit, the Member acknowledges that he or she:

- a) shall not receive curative care but rather palliative care solely for reducing the intensity of and management of the Member's Terminal Illness;
- b) waives the right to the PPO standard benefits for treatment of the Terminal Illness and related conditions; and
- c) retains all normal coverage, as set forth in the Member's Certificate, for Covered Services not related to the Terminal Illness.

3.11.2 Limitations. Covered Services provided which are unrelated to the Member's Terminal Illness shall not be covered under the PPO's Hospice benefit, but shall be covered as set forth in the applicable provisions of the Member's Certificate.

L. Section **3.13, Implanted Devices,** is deleted from the Certificate and replaced with the following:

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

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

M. Section 3.14, Mastectomy and Breast Cancer Reconstructive Surgery, is deleted from the Certificate in its entirety and replaced with the following:

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

- a) all stages of reconstruction of the breast on which the mastectomy was performed; and
- b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c) initial and subsequent Prosthetic Devices to replace the removed breast or portions thereof following a mastectomy will be provided; and
- d) treatment of physical complications at all stages of the mastectomy including lymphedemas.

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

N. Section 3.15, Maternity Care, is deleted from the Certificate in its entirety and replaced with the following:

3.15 Maternity Care. Hospital and physician care are provided for maternity care. Maternity care includes the following services for the mother during the term of pregnancy, delivery and the postpartum period: hospital services for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following caesarean section delivery (a shorter length of stay may be authorized if determined by the attending physician in consultation with the mother that the mother and newborn meet medical criteria for an early safe discharge) including use of the delivery room; medical services, including operations and special procedures such as caesarean section; anesthesia; injectables; and X-ray and laboratory services. When a discharge occurs within forty-eight (48) hours following a hospital admission for a normal vaginal delivery or within ninety-six (96) hours of care following caesarean delivery, home health care service is provided for one (1) home health care visit for an early discharge. The home health care visit shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the Provider. Certified licensed nurse midwife Provider services shall be covered only if provided in a hospital Provider or an appropriately licensed free-standing birthing center Provider. Subject to the thirty-one (31) day enrollment limitations for newborns, Covered Services related to newborn care are set forth in Section 3.18 of this Certificate.

Treatment of unexpected complications of pregnancy and care for unexpected early delivery are covered as Emergency Services as set forth in Section 3.7 of this Certificate.

3.15.1 Cost Sharing. The office visit Copayment or Coinsurance applies only to the first prenatal visit (after pregnancy has been confirmed) and will not apply to subsequent prenatal or postpartum visits. Each covered day of a hospital stay and related physician services for maternity are subject to the inpatient hospital Copayment or Coinsurance specified on the Schedule of Benefits. The inpatient hospital Copayment shall be limited to a maximum

dollar amount per hospital admission as set forth on the Schedule of Benefits. A postpartum home health care visit within forty-eight (48) hours for early discharges is not subject to any Copayment, Deductible or Coinsurance amounts under this Section.

- 3.15.2 **Childbirth Preparedness Classes.** Childbirth preparedness classes for education focused on preparing for labor and the birth of a child are covered for pregnant female Members up to a \$100 limit per Benefit Period. Such classes are intended to prepare female Members for childbirth and may not be related solely to child rearing. Classes may be provided by a Preferred or Non-Preferred Provider. In order to be reimbursed by the PPO for a childbirth preparedness class, the Member must follow the requirements of Section 8.14, of the Certificate. However, the Member is **not required** to follow the claim form requirements set forth in Section 8.14.1 of the Certificate; instead, the Member should submit a copy of the childbirth preparedness class receipt indicating the payment amount the completion date of the class.

- O. Section **3.16, Mental Health and Substance Abuse Services**, is deleted from the Certificate and replaced with the following:

3.16 Mental Health and Substance Use Disorder Services. Behavioral health services include services for the treatment of mental health conditions and Substance Use Disorder conditions. Behavioral health services will be classified as mental health services and/or Substance Use Disorder services when primarily associated with a mental health or Substance Use Disorder condition, as indicated by a Provider, regardless of the type or location of the Covered Service.

The following services are covered when obtained from a licensed mental health facility, licensed Substance Use Disorder facility, licensed psychiatrist, a licensed clinical psychologist, or other licensed behavioral health professionals when Medically Necessary to treat mental health conditions:

- Inpatient services, upon Precertification:
 - Treatment in an acute care hospital or psychiatric hospital (including room and board);
 - Treatment in a residential treatment facility (including room and board). "Residential treatment" is an environment that treats patients who require daily assessment or treatment and 24-hour monitoring but do not require acute care services. In order to provide this level of care, residential treatment facilities have on-site nursing during daytime hours and 24/7 access to psychiatric, medical, and other clinical services either onsite or in close enough proximity to provide rapid response. With respect to treatment of Substance Use Disorders, "residential treatment" is an environment equivalent to American Society of Addiction Medicine levels of care 3.5 and 3.7;
 - Hospital-based and non-hospital-based inpatient withdrawal management (detoxification) services (including room and board); or
 - Ancillary services related to inpatient stay, including professional services of a physician, psychologist, nurse, certified mental health counselor, certified addiction counselor, or other trained staff; individual, group and family psychotherapy or counseling; electroconvulsive therapy; medical, psychological and laboratory testing; equipment use and supplies; and diagnostic and other therapeutic services.
- Outpatient services, upon Precertification:
 - Electroconvulsive therapy;
 - Intensive outpatient program;
 - Partial hospitalization program;
 - Outpatient detoxification/withdrawal management services;
 - Psychological/Neuropsychological Testing;
 - Transcranial Magnetic Stimulation;
 - Applied Behavioral Analysis (ABA); or

- Other outpatient services deemed Medically Necessary for the treatment of a behavioral health condition.
- Office visits and outpatient therapy, including:
 - Professional services of a physician, psychologist, nurse, certified licensed mental health counselor, certified addiction counselor, or other trained staff;
 - Individual, group and family psychotherapy or counseling;
 - Psychological and neuropsychological testing; or
 - Urgent care for behavioral health conditions.

Mental health and Substance Use Disorder services are subject to the Cost Sharing set forth on the Schedule of Benefits.

P. Section **3.17, Mental Health and Substance Abuse Services**, is deleted from the Certificate in its entirety and restated in Section 3.16.

Q. Section **3.18, Newborn Coverage** is deleted from the Certificate and replaced with the following:

3.18 Newborn Coverage. Newborn children are covered as Members from birth for the first thirty-one (31) days of life. Such coverage shall include Medically Necessary care for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage beyond the first thirty-one (31) days will only be provided in accordance with the provisions of Section 6.2.3.

R. Section **3.19, Oral Surgery**, is amended to delete subsection **3.19.5, Deep Sedation or General Anesthesia and Related Professional Services** and replace it with the following and subsection **3.19.6, Cost Sharing**, is added to the Certificate:

3.19.5 General Anesthesia and Associated Medical Costs provided in connection with an inpatient or outpatient oral surgery procedure are covered as set forth in Section 3.35 of this Certificate.

3.19.6 Cost Sharing. Cost Sharing for Oral Surgery is based on the type of facility as set forth on the Schedule of Benefits under “Hospital and Ambulatory Surgical Center Services”.

S. Section **3.20, Ostomy Supplies**, is deleted from the Certificate and replaced with the following:

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

T. Sections **3.22 through 3.22.7, Preventive Services**, are deleted from the Certificate and replaced with the following:

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

3.22.1 Periodic health assessments including:

a) physical examination (s).

3.22.1.1 Periodic Health Assessment Cost Sharing. For the Cost Sharing applicable to the periodic health assessments set forth in Section 3.22.1, above, refer to the Schedule of Benefits under “PHYSICIAN OFFICE SERVICES”. The Cost Sharing associated with these Covered Services will differ depending upon

whether the services were provided by a Primary Care Physician or a Specialist.

3.22.2 **Additional Preventive Services listed in Exhibit 4.** The preventive services listed in Exhibit 4 are not subject to Cost Sharing only when obtained from a Preferred Provider. Preventive services listed in Exhibit 4 obtained from a Non-Preferred Provider are not covered. For the Cost Sharing applicable to these preventive services, refer to the Schedule of Benefits under “PREVENTIVE SERVICES”.

U. Section 3.23, **Pulmonary Rehabilitation**, is deleted from the Certificate and replaced with the following:

3.23 Pulmonary Rehabilitation. Outpatient pulmonary rehabilitation is covered subject to the Benefit Limit and Cost Sharing set forth on the Schedule of Benefits.

V. Section 3.24, **Rehabilitative Services**, is deleted from the Certificate and replaced with the following:

3.24 Rehabilitative Services.

3.24.1 **Physical and Occupational Therapy Services.** Physical and occupational therapy, on either an outpatient or inpatient basis, is covered; however, Precertification is required for outpatient/inpatient rehabilitative facility services provided by Non-Preferred Providers.

3.24.1.1 **Physical Therapy for Back/Neck-Related Pain.** Upon Precertification, physical therapy for back/neck-related pain is covered. Cost Sharing applicable to the first ten (10) physical therapy visits for back/neck-related pain will be bundled into two (2) series of five (5) visits per series. Cost Sharing applicable to each series is noted on the Schedule of Benefits. Cost Sharing applicable to each visit subsequent to the tenth (10th) visit is also noted on the Schedule of Benefits.

3.24.2 **Speech Therapy Services.** Speech therapy, on either an outpatient or inpatient basis is covered; however, Precertification is required for outpatient/inpatient rehabilitative facility services provided by Non-Preferred Providers.

W. Section 3.26, **Select Injectable Drugs**, is deleted from the Certificate and replaced with the following:

3.26 Select Injectable Drugs. Subject to the terms and conditions set forth in this Certificate, the following injectable drugs are a Covered Service when provided by a Preferred Provider.

- Abilify Asimtufii (aripiprazole)
- Abecma (idecabtagene vicleucel)
- Adstiladrin (nadofaragene firadenovec-vnecg)
- Adzyna (ADAMTS13, recombinant-krhn)
- Agamree (vamorolone)
- Altuviiio (Antihemophilic factor [recombinant], Fc-VWF-XTEN fusion protein-ehtl)
- Alyglo (immunoglobulin intravenous, human-stwk)
- Alymsys (bevacizumab-maly)
- Amtagvi (lifileucel)
- Amvuttra (vutrisiran)
- Andexxa (andexanet alfa)
- Anktiva (nogapendekin alpha inbalicept-pnlm)
- Aphexda (motixafortide)
- Aponvie (aprepitant)
- Aralast (alpha1-proteinase inhibitor, human)
- Aranesp (darbepoetin alfa)
- Aristada (aripiprazole Lauroxil)
- Arranon (nelarabine)

- Artesunate for Injection
- Arzerra (ofatumumab)
- Asceniv (immune globulin intravenous, human -slra)
- Asparlas (calaspargase pegol-mknl)
- Atryn (Antithrombin, Recombinant)
- Aucatzyl (obecabtagene autoleucel)
- Avastin (bevacizumab)^(see foot note)
- Aveed (testosterone undecanoate)
- Avsola (infliximab-axxq)
- Avycaz (ceftazidime/avibactam)
- Azedra (iobenguane I 131)
- Balfaxar (prothrombin complex concentrate (human) [(Factors II, VII, IX, X), Protein C, and Protein S])
- Bavencio (avelumab)
- Baxdela IV (delafloxacin meglumine)
- Bebulin (Antihemophilic Factor IX Complex, Human)
- Beleodaq (belinostat)
- Belrapzo (bendamustine)
- bendamustine (generic Treanda)
- Bendeka (bendamustine hydrochloride)
- Benefix (Antihemophilic Factor IX, Recombinant)
- Benlysta (belimumab)
- Beovu (brolucizumab-dbll)
- Beqvez (fidanacogene elaparvovec-dzkt)
- Berinert (C1 esterase inhibitor, human)
- Besponsa (inotuzumab ozogamicin)
- Beyfortus (nirsevimab-alip)
- Bivigam (immune globulin intravenous)
- Bizengri (zenocutuzumab-zbco)
- Blincyto (blinatumomab)
- Botox (botulinum toxin type A)
- Breyanzi (lisocabtagene maraleucel)
- Brineura (cerliponase alfa)
- Briumvi (ublituximab-xiiy)
- Brixadi (buprenorphine)
- Byooviz (ranibizumab-nuna)
- Cabenuva (cabotegravir and rilpivirine)
- Cablivi (caplacizumab-yhdp)
- Camcevi (leuprolide)
- Carimune (intravenous immune globulin)
- Carvykti (ciltacabtagene autoleucel)
- Casgevy (exagamglogene autotemcel)
- Cerezyme (imiglucerase)
- Cimerli (ranibizumab-eqrn)
- Cimzia IV (certolizumab pegol)
- Cinqair (reslizumab)
- Cinryze (C1 esterase inhibitor, human)
- Cinvanti (aprepitant)
- Clolar (clofarabine)
- Coagadex (Factor X (Human))
- Columvi (glofitamab-gxhm)
- Corifact (factor XIII concentrate)
- Cosela (trilaciclib)
- Cosentyx IV (secukinumab)
- Cresemba (isavuconazonium sulfate)
- Crysvita (burosumab-twza)

- Cubicin/Cubicin RF (daptomycin)*
- Cutaquig (immune globulin subcutaneous, human -hipp)
- Cuvitru (subcutaneous immune globulin)
- Cyramza (ramucirumab)
- Dacogen (decitabine)*
- Dalvance (dalbavancin)
- Danyelza (naxitamab)
- Daptomycin
- Darzalex (daratumumab)
- Darzalex Faspro (daratumumab/hyaluronidase)
- Datroway (datopotamab deruxtecan-dlnk)
- Daxxify (daxibotulinumtoxinA-lanm)
- Decitabine
- Dextenza (dexamethasone ophthalmic)
- Dexycu (dexamethasone ophthalmic)
- Duopa (carbidopa/levodopa)
- Durolane (sodium hyaluronate)
- Durysta (bimatoprost)
- Dysport (botulinum toxin Type A)
- Elaprase (idursulfase)
- Elelyso (taliglucerase alfa)
- Elevidys (delandistrogene moxeparvovec-rokl)
- Elfabrio (pegunigalsidase alfa-iwxj)
- Eligard (leuprolide)
- Elitek (rasburicase)
- Eloctate (Antihemophilic Factor VIII, Recombinant, FC)
- Eloxatin (oxaliplatin)*
- Elrexio (elranatamab-bcmm)
- Elzonris (tagraxofusp-erzs)
- Empaveli (pegcetacoplan)
- Empliciti (elotuzumab)
- Enhertu (fam-trastuzumab deruxtecan-nxki)
- Enjaymo (sutimlimab-jome)
- Entyvio (vedolizumab)
- Epkinly (epcoritamab-bysp)
- Epogen (epoetin alfa, recombinant)
- Epoprostenol Sodium
- Epysqli (eculizumab-aagh)
- Erbitux (cetuximab)
- Erwinaze (asparaginase)
- Erzofri (paliperidone ER suspension)
- Esperoct (antihemophilic factor, (recombinant) glycopegylated-exei)
- Esperoct (turoctocog alfa pegol)
- Euflexxa (hyaluronate sodium)
- Evenity (romosozumab-aqqg)
- Evkeeza (evinacumab)
- Exondys 51 (eteplirsen)
- Eylea (aflibercept)
- Eylea HD (aflibercept)
- Fabrazyme (agalsidase beta)
- Fasenra (benralizumab)
- Faslodex (fulvestrant)
- Feiba NF (Anti-inhibitor Coagulant Complex)
- Fensolvi (leuprolide)
- Feraheme (ferumoxytol)
- Fetroja (cefiderocol sulfate tosylate)

- IVIG (intravenous immune globulin)
- Ixempria (ixabepilone)
- Izervay (avacincaptad pegol)
- Jelmyto (mitomycin)
- Jemperli (dostarlimuab-gxly)
- Jevtana (cabazitaxel)
- Jivi (antihemophilic factor (recombinant), PEGylated-aucI)
- Kadcyla (ado-trastuzumab emtansine)
- Kalbitor (ecallantide)
- Kanjinti (trastuzumab-anns)
- Kanuma (sebelipase alfa)
- Kcentra (prothrombin complex concentrate)
- Kebilidi (eladocogene exuparvovec-tneq)
- Kepivance (palifermin)
- Keytruda (pembrolizumab)
- Khapzory (levoleucovorin)
- Kimmtrak (tebentafusp-tebn)
- Kimyrsa (oritavancin)
- Koate-DVI (Antihemophilic Factor VIII, Human)
- Kogenate FS (Antihemophilic Factor VIII, Recombinant)
- Korsuva (difelikefalin)
- Kovaltry (antihemophilic factor)
- Krystexxa (pegloticase)
- Kymriah (tisagenlecleucel)
- Kyprolis (carfilzomib)
- Lamzede (velmanase alpha-tycv)
- Lantidra (donislecel-jujn)
- Lemtrada (alemtuzumab)
- Lenmeldy (atidarsagene autotemcel)
- Leqembi (lecanemab-irmb)
- Leqvio (inclisiran)
- Leukine (sargramostim)
- Libtayo (cemiplimab-rwlc)
- Loqtorzi (toripalimab-tpzi)
- Lucentis (ranibizumab)
- Lumizyme (alglucosidase alfa)
- Lumoxiti (moxetumomab pasudotox-tdfk)
- Lunsumio (mosunetuzumab-axgb)
- Lupaneta (leuprolide acetate/norethindrone acetate)
- Lupron Depot (leuprolide acetate)
- Lutathera (lutetium lu 177 dotatate)
- Luxturna (voretigene neparvovec-rzyl)
- Lyfgenia (lovotibeglogene autotemcel)
- Macrilen (macimorelin)
- Macugen (pegaptanib)
- Makena (hydroxyprogesterone caproate injection)*
- Margenza (margetuximab)
- Mepsevii (vestronidase Alfa-vjbk)
- Mircera (methoxy polyethylene glycol-epoetin beta)
- Mitosol (mitomycin)
- Monjuvi (tafasitamab)
- Monoclata-P (Antihemophilic Factor VIII, Human)
- Mononine (Antihemophilic Factor IX, Human)
- Monovisc (hyaluronan)
- Mozobil (plerixafor)
- Mvasi (bevacizumab-awwb)

- Mylotarg (gemtuzumab ozogamicin)
- Myobloc (rimabotulinumtoxin B)
- Naglazyme (galsulfase)
- Neulasta (pegfilgrastim)
- Neupogen (filgrastim)
- Nexviazyme (avalglucosidase alfa-ngpt)
- Nivestym (filgrastim-aafi)
- Novoseven RT (Coagulation Factor VIIa, Recombinant)
- N-Plate (romiplostim)
- Nucala (mepolizumab)
- Nulibry (fosdenopterin)
- Nulojix (belatacept)
- Nuwiq (Antihemophilic Factor VIII, Recombinant)
- Nuzyra IV (omadacycline tosylate)
- Nypozi (filgastrim-cbqv)
- Nyvepria (pegfilgrastim)
- Nyvepria (pegfilgrastim-apgf)
- Obizur (Antihemophilic Factor VIII, Recombinant, Porcine Sequence)
- Ocrevus (ocrelizumab)
- Octagam (intravenous immune globulin)
- Ogivri (trastuzumab-dkst)
- Olinvyk (oliceridine)
- Omisirge (omidubicel-onlv)
- Omvoh (mirikizumab-mrkz)
- Oncaspar (pegaspargase)
- Onivyde (irinotecan (liposomal))
- Onpattro (patisiran)
- Ontruzant (trastuzumab)
- Opdivo (nivolumab)
- Opdivo Qvantig (nivolumab & hyaluronidase)
- Opdualag (nivolumab/relatlimab-rmbw)
- Orbactiv (ortivancin)
- Orenia IV (abatacept)
- Orthovisc (hyaluronate sodium)
- Otulfi (ustekinumab-aauz)
- Oxaliplatin
- Oxlumo (lumasiran)
- Ozurdex (dexamethasone [ophthalmic implant])
- Paclitaxel protein-bound
- Padcev (enfortumab vedotin-ejfv)
- Panzyga (immune globulin intravenous, human - ifas)
- Parsabiv (etelcalcetide)
- Pavblu (aflibercept-ayyh)
- Pedmark (sodium thiosulfate)
- Pemfexy (pemetrexed)
- Perjeta (pertuzumab)
- Perseris (risperidone)
- Phesgo (pertuzumab, trastuzumab, and hyaluronidase)
- Piasky (crovalimab-akkz)
- Pluvicto (lutetium Lu 177 vipivotide tetraxetan)
- Polivy (polatuzumab vedotin-piiq)
- Pombiliti (cipaglucosidase alfa-atga)
- Portrazza (necitumumab)
- Poteligeo (mogamulizumab-kpkc)
- Praxbind (idarucizumab)
- Prevymis (letermovir)

- Prialt (ziconotide)
- Privigen (intravenous immune globulin)
- Probuphine (buprenorphine)
- Procrit (epoetin alfa, recombinant)
- Profilnine SD (Antihemophilic Factor IX Complex, Human)
- Prolastin (alpha1-proteinase inhibitor, human)
- Prolia (denosumab)
- Provenge (sipuleucel-T)
- Pyzchiva (ustekinumab-ttwe)
- Qalsody (tofersen)
- Qutenza (capsaicin transdermal)
- Quzyttir (cetirizine injection)
- Radicava (edaravone)
- Rapivab (peramivir)
- Rebinyn (coagulation factor IX (recombinant), glycopegylated)
- Reblozyl (luspatercept-aamt)
- Rebyota (fecal microbiota, live-jslm)
- Recarbrio (imipenem/cilastatin sodium/relebactam)
- Recombinate (Antihemophilic Factor VIII, Recombinant)
- Releuko (filgrastim-ayow)
- Remicade (infliximab)
- Remodulin (treprostinil)*
- Renflexis (infliximab-abda)
- Retacrit (epoetin alfa-epbx)
- Retisert (fluocinolone acetonide [ophthalmic implant])
- Revcovi (elapegademase-lvlr)
- Rezzayo (rezafungin)
- Riabni (rituximab-arrx)
- Risperdal Consta (risperidone microspheres)
- Rituxan (rituximab)
- Rituxan Hycela (rituximab/hyaluronidase)
- Rixubis (coagulation factor IX)
- Roctavian (valoctocogene roxaparvovec-rvox)
- Rolvedon (eflapegrastim-xnst)
- Ruconest (C1 esterase inhibitor [recombinant])
- Ruxience (rituximab-pvvr)
- Rybrevant (amivantamab-vmjw)
- Rykindo (risperidone extended-release injection)
- Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)
- Ryplazim (plasminogen, human-tvmh)
- Rystiggo (rozanolixizumab-noli)
- Rytelo (imetelstat)
- Sandostatin LAR (octreotide)
- Saphnelo (anifrolumab-fnia)
- Sarelisa (isatuximab-irfc)
- Scenesse (afamelanotide)
- Selarsdi (ustekinumab-aekn)
- Sezaby (phenobarbital sodium)
- Signifor LAR (pasireotide)
- Simponi Aria (golimumab)
- Sivextro (tedizolid)
- Skysona (elivaldogene autotemcel)
- Soliris (eculizumab)
- Somatuline Depot (lanreotide)
- Spevigo (spesolimab-sbzo)
- Spinraza (nusinersen)

- Spravato (esketamine)
- Stelara (ustekinumab)
- Stimufend (pegfilgrastim-fpgk)
- Sublocade (buprenorphine)
- Supartz/Supartz FX (hyaluronate sodium)
- Supprellin LA (histrelin acetate)
- Surfaxin (lucinactant)
- Sustol (granisetron)
- Susvimo (ranibizumab implant)
- Syfovre (pegcetacoplan)
- Sylvant (siltuximab)
- Synagis (palivizumab)
- Synribo (omacetaxine mepesuccinate)
- Synvisc (hylan G-F 20)
- Synvisc-One (hylan G-F 20)
- Talvey (talquetamab-tgvs)
- Tecartus (brexucabtagene autoleucel)
- Tecelra (afamitresgene autoleucel)
- Tecentriq (atezolizumab)
- Tecvayli (teclistamab-cqyv)
- Teflaro (ceftaroline fosamil)
- Tepadina (thiotepa)
- Tepezza (teprotumumab-trbw)
- Terlivaz (terlipressin)
- Tevimbra (tislelizumab-jsgr)
- Tezspire (tezepelumab-ekko)
- Thrombate III (Antithrombin III, Human)
- Thyrogen (thyrotropin alfa)
- Tivdak (tisotumab vedotin-tftv)
- Tofidence (tocilizumab-bavi)
- Torisel (temsirolimus)
- Trazimera (trastuzumab-qyyp)
- Treanda (bendamustine)*
- Trelstar (triptorelin)
- treprostinil
- Tretten (Factor XIII A-Subunit)
- Triluron (hyaluronate and derivatives)
- Triptodur (triptorelin pamoate)
- Trisenox (arsenic trioxide)
- Trivisc (sodium hyaluronate)
- Trodelvy (sacituzumab govitecan)
- Trogarzo (ibalizumab-uiyk)
- Truxima (rituximab-abbs)
- Tyenne (tocilizumab-aazg)
- Tysabri (natalizumab)
- Tzield (teplizumab-mzwv)
- Udenyca (pegfilgrastim-cbqv)
- Udenyca On-Body (pegfilgastrim-cbqv)
- Ultomiris (ravulizumab-cwvz)
- Unituxin (dinutuximab)
- Uplizna (inebilizumab)
- Uzedy (risperidone)
- Vabomere (meropenem/vaborbactam)
- Vabysmo (faricimab)
- Varizig (varicella zoster immuno globulin [human])
- Vectibix (panitumumab)

- Vegzelma (bevacizumab-adcd)
- Velcade (bortezomib)
- Veletri (epoprostenol)*
- Veopoz (pozelimab-bbfg)
- Viltepso (viltolarsen)
- Vimizim (elosulfase alfa)
- Visco-3 (sodium hyaluronate)
- Vistide (cidofovir)
- Visudyne (verteporfin)
- Vivimusta (bendamustine)
- Vivitrol (naloxone injection)
- Vonvendi (von willebrand factor)
- Voraxaze (glucarpidase)
- VPRIV (velaglucerase alfa)
- Vyalev (foscarbidopa/foslevodopa)
- Vyepti (eptinezumab-jjmr)
- Vyjuvek (beremagene geperpavec-svdt)
- Vyloy (zolbetuximab-clzb)
- Vyondys 53 (golodirsen)
- Vyvgart (efgartigimod alfa-fcab)
- Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)
- Vyxeos (daunorubicin/cytarabine (liposomal))
- Wezlana (ustekinumab-auub)
- Wilate (Antihemophilic Factor VIII/von Willebrand Factor Complex)
- Xacduro (sulbactam/durlobactam)
- Xembify (immune globulin subcutaneous, human -klhw)
- Xenleta (lefamulin)
- Xenpozyme (olipudase alpha-rpcp)
- Xeomin (incobotulinumtoxina)
- Xerava (eravacycline)
- Xgeva (denosumab)
- Xiaflex (collagenase clostridium histolyticum)
- Xipere (triamcinolone acetate injectable suspension)
- Xofigo (radium RA 223 dichloride)
- Xolair (omalizumab)
- Xyntha (Antihemophilic Factor VIII, Recombinant, PAF)
- Ycanth (cantharidin)
- Yervoy (ipilimumab)
- Yescarta (axicabtagene ciloleucel)
- Yesintek (ustekinumab-kfce)
- Yondelis (trabectedin)
- Yutiq (fluocinolone acetate)
- Zaltrap (ziv-aflibercept)
- Zarxio (filgrastim-sndz)
- Zemaira (alpha 1-proteinase inhibitor, human)
- Zemdri (plazomicin sulfate)
- Zepzelca (lurbinectedin)
- Zerbaxa (ceftolozane/tazobactam)
- Zevalin (ibritumomab tiuxetan)
- Ziextenzo (pegfilgrastim-bmez)
- Ziihera (zanidatamab-hrii)
- Zilretta (triamcinolone acetate)
- Zinplava (bezlotoxumab)
- Zirabev (bevacizumab-bvzr)
- Zolgensma (Onasemnogene Apeparvovec)
- Zulresso (brexanolone)

- Zynlonta (loncastuximab tesirine-lpyl)
- Zynteglo (betibeglogene autotemcel)
- Zynyz (retifanlimab-dlwr)
- Zyprexa Relprevv (olanzapine)

* Generic available and also included on this list.

^ Cost share will not be applied for a diagnosis of Age Related Macular Edema

3.26.1 Cost Sharing.

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

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

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

X. Section 3.29.2, Precertification, is deleted from the Certificate and replaced with the following:

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

Y. Human Leukocyte Antigen (HLA) Typing is no longer subject to a specific dollar Benefit Limit, therefore, **Section 3.29.6, Human Leukocyte Antigen (HLA) Typing,** is deleted from the Certificate.

Z. Section 3.29.8, Travel, Lodging and Meal Expense Reimbursement, is deleted from the Certificate and replaced with the following:

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

AA. Section 3.30.2, Scheduled Services, is deleted from the Certificate and replaced with the following:

3.30.2 Scheduled Services. Medically necessary non-emergency ambulance transportation is covered when provided by Preferred Providers and Precertification has been received. These transports are subject to the Cost Sharing set forth on the Schedule of Benefits.

BB. Section 3.32, Urological Supplies, is deleted from the Certificate and replaced with the following:

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

CC. **Section 3.33, Voluntary Family Planning Services**, is deleted from the Certificate and replaced with the following:

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

- a) professional services related to the prescribing, fitting and/or insertion of a contraceptive device covered by this Certificate; and
- b) services for diagnosis of infertility (except infertility procedures which are specifically excluded in this Certificate in Sections 4.17 and 4.28).

DD. **Section 3.35, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**, is added to the Certificate as follows:

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

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

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

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

- a) has an existing medical condition unrelated to the dental or oral surgical procedure; or
- b) has a medical condition that precludes the use of local anesthetic or in which local anesthetic is ineffective; or
- c) is a child age seven (7) or younger; or
- d) is developmentally disabled and for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under General Anesthesia.

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

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

EE. **Section 3.36, Infusion Therapy**, is added to the Certificate as follows:

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

FF. Section 3.37, Injectable Drugs, is added to the Certificate as follows:

3.37 Injectable Drugs. Injectable drugs are covered and subject to the Cost Sharing set forth in the Schedule of Benefits. Select injectable drugs are covered as set forth separately in Section 3.26.

GG. Section 3.38, Spinal Injections, is added to the Certificate as follows:

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

HH. Section 3.39, Substance Use, is added to the Certificate as follows:

3.39 See “**Mental Health and Substance Use Disorder Services**”.

II. INTENTIONALLY LEFT BLANK

JJ. Section 3.41, Impacted Wisdom Teeth, is added to the Certificate as follows:

3.41 Impacted Wisdom Teeth. Subject to Section 3.41.1 below, Cost Sharing set forth on the Schedule of Benefits and applicable Exclusions set forth in Section 4, the PPO will cover consultation and services related to the extraction of partially or totally bony third molars when performed by a Preferred Provider.

3.41.1 Hospital and Ambulatory Surgical Center Services provided on an inpatient or outpatient basis in connection with the extraction of partially or totally bony impacted third molars, are covered if the hospital services are required for an existing medical condition unrelated to the dental or oral surgical procedure or as set forth in Certificate Section **3.35, General Anesthesia and Associated Medical Costs for Oral Surgery and/or Dental Care**. Such coverage must be authorized in advance by the PPO.

KK. Section 3.42, Refractions, is added to the Certificate as follows:

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

LL. Section 3.43, Chemotherapy Medications, is added to the Certificate as follows:

3.43 Chemotherapy Medications.

Upon Precertification, the PPO will cover Medically Necessary, FDA approved Chemotherapy medications in the treatment of cancer. Such coverage will include Chemotherapy medications that are administered intravenously, injected, or orally.

Coverage and Cost Sharing for a prescribed, orally administered Chemotherapy medication shall not be any less favorable than the coverage provided or Cost Sharing applicable for intravenously administered or injected Chemotherapy medications.

As used in this section, “Chemotherapy medication” means a medication prescribed by a treating health care practitioner that is necessary to kill or slow the growth of cancerous cells.

MM. Section 3.44, Hepatitis C – Center of Excellence, is added to the Certificate as follows:

3.44 Hepatitis C – Center of Excellence

3.44.1 Definition. For purposes of this Section 3. 44, Center of Excellence (“COE”) shall mean a Preferred Health Care Provider designated by the PPO. Members should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

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

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

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

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

NN. Section 3.45, Amyloidosis– Center of Excellence, is added to the Certificate as follows:

3.45 Amyloidosis – Center of Excellence

3.45.1 Definition. For purposes of this Section 3.45, Center of Excellence (“COE”) shall mean a Preferred Health Care Provider designated by the PPO. Members should contact the Customer Service Team at the telephone number on the back of their Identification Card to obtain a list of designated Centers of Excellence.

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

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

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

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

OO. Section 3.46, Autism Spectrum Disorder Services, is added to the Certificate as follows:

3.46 Autism Spectrum Disorder Services.

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

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

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

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

Mandated Benefits means any additional Covered Services as required by state or Federal law in effect for the Subscriber and all Family Dependents enrolled under the Certificate.

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

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

- a) prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner;
- b) provided by an Autism Spectrum Disorder Provider;
- c) provided by a person, entity or group that works under the direction of an Autism Spectrum Disorder Provider.

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

BENEFITS.

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

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

3.46.1.1.1 **Cost Sharing.** Cost Sharing for pharmacy care services shall be as set forth on the Schedule of Benefits listed under “Outpatient Prescription Drug Coverage”.

3.46.1.2 **Psychiatric Care Services.** Psychiatric Care Services include direct or consultative services provided by a physician Autism Spectrum Disorder Provider who specializes in psychiatry.

3.46.1.2.1 **Cost Sharing.** Cost Sharing for psychiatric care services shall be as set forth on the Schedule of Benefits listed under “Mental Health and substance use services/Outpatient mental health services” - “Outpatient Professional Services”.

3.46.1.3 **Psychological Care Services.** Psychological Care Services include direct or consultative services provided by a psychologist Autism Spectrum Disorder Provider.

3.46.1.3.1 **Cost Sharing.** Cost Sharing for psychological care services shall be as set forth on the Schedule of Benefits listed under “Mental Health and substance use services/Outpatient mental health services” - “Outpatient Professional Services”.

3.46.1.4 **Rehabilitative and Habilitative Care Services.** Rehabilitative and habilitative care services include professional Autism Spectrum Disorder Provider services and treatment programs, including Applied Behavioral Analysis, provided to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

3.46.1.4.1 **Cost Sharing.** Cost Sharing for rehabilitative and habilitative care services shall be as set forth on the Schedule of Benefits listed under “Outpatient physician services” - “Specialist Visit”.

3.46.1.5 **Therapeutic Care Services.** Therapeutic Care Services require Precertification and include services provided by speech language pathologist, occupational therapist or physical therapist Autism Spectrum Disorder Providers. Therapeutic Care Services must be provided by a Preferred Provider.

3.46.1.5.1 **Cost Sharing.** Cost Sharing for therapeutic care services shall be as set forth on the Schedule of Benefits listed under “Outpatient physician services” - “Specialist Visit”.

PP. **Section 3.27 – Skilled Nursing Facility Services** is deleted from the Certificate and replaced with the following:

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

Visit limits do not apply to mental health/substance use disorder primary diagnosis.

5. **SECTION 4. EXCLUSIONS.**

A. **Section 4.1, Acupuncture,** is deleted from the Certificate in its entirety and replaced within the following:

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

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

- B.** Section **4.6, Biofeedback**, is deleted from the Certificate. Biofeedback is now referenced in Section **4.1, Alternative Therapies**, as a type of alternative therapy that is not covered.
- C.** Section **4.7, Blood or Other Body Tissue and Fluids, Including Storage**, is deleted from the Certificate and replaced with the following:
- 4.7 Blood or Other Body Tissue and Fluids, Including Storage.** Blood, and the storage and banking of autologous and cord blood, body tissue and fluids is **NOT COVERED**.
- D.** Section **4.8, Breast Surgery**, is deleted from the Certificate and replaced, as follows:
- 4.8 Breast Surgery.** Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 of this Certificate.
- E.** Section **4.10, Complications Resulting from a Non-Covered Procedure or Service**, is deleted from the Certificate.
- F.** Section **4.12, Cosmetic Surgery**, is deleted from the Certificate and replaced with the following:
- 4.12 Cosmetic Surgery.** Restorative or reconstructive surgery or medical services performed for cosmetic purposes which is not expected to result in significantly improved physiologic function as determined by the PPO, is **NOT COVERED**, except as provided in Sections 3.14, 3.25.1 or 3.25.2 of this Certificate.
- G.** Section **4.14, Dentistry**, is deleted from the Certificate in its entirety and replaced as follows:
- 4.14 Dentistry.** The PPO does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, analgesia, 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: a) expenses related to the emergency treatment of sound natural teeth as set forth in Section 3.19.2 of this Certificate (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth), b) General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.35 and c) Impacted Wisdom Teeth as set forth in Certificate Section 3.41.
- H.** Section **4.15, Drug Maintenance Programs** is deleted from the Certificate.

I. Section **4.16, Drugs**, is deleted from the Certificate and replaced with the following:

4.16 Drugs. Prescription drugs provided on an outpatient basis are **NOT COVERED** unless expressly set forth in Certificate Sections 3.3.3 (Diabetic Medical Equipment, Supplies, Prescription Drugs and Services/Prescription Drugs), 3.29.7 (Transplant Services and Authorization Requirements/Self-Administered Prescription Drugs), 3.46 (Autism Spectrum Disorder Services), as set forth in **Exhibit 4, Preventive Services**, or as may be explicitly provided under the terms of an **Outpatient Prescription Drug Rider** if such Rider is listed on the Schedule of Benefits as being in place with this Certificate.

J. Section **4.17, Drugs and Devices for Purposes of Contraception**, is deleted from the Certificate in its entirety and replaced with the following:

4.17 Drugs and Devices for Purposes of Contraception. Drugs and devices for purposes of contraception are **NOT COVERED** except as may be explicitly provided under the terms of **Exhibit 4, Preventive Services** and the **Outpatient Prescription Drugs Rider** if such a Rider is listed on the Schedule of Benefits as being in place with this Certificate.

K. Section **4.18, Elective Abortions**, is deleted in its entirety and replaced with the following:

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

L. Section **4.20, Failure to Obtain Precertification**, is deleted from the Certificate and replaced with the following:

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

4.20.1 All non-emergency inpatient hospital admissions; and

4.20.2 the procedures and services set forth in **Exhibit 3, Precertification List**, of this Certificate.

M. Section **4.22, Gender Reassignment**, is deleted from the Certificate and replaced with the following:

4.22 Gender Transition Services. Gender dysphoria (discontent) and gender confirmation treatment, including designated prevention and long-term care clinical and laboratory monitoring services, and surgical treatment is **NOT COVERED**.

N. Section **4.45, Private Duty Nursing**, is deleted from the Certificate and replaced with the following:

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

O. Section **4.46, Refraction Examinations**, is deleted from the Certificate and replaced with the following:

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

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

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

iii) Refraction services that are not obtained from Preferred Providers.

- P. Section **4.52, Services Provided by a Member's Relative or Self**, is deleted from the Certificate and replaced with the following:
- 4.52 Services Provided by a Member's Relative or Self.** Services rendered by a physician Provider who is the spouse, child, parent, grandparent, aunt, uncle, niece, nephew, sibling or persons who ordinarily reside in the household of the Member are **NOT COVERED**. Services rendered by one's self are **NOT COVERED**.
- Q. Section **4.53, Services Related to or Required by a Non-Covered Service**, is deleted from the Certificate.
- R. Section **4.55, Transportation Services**, is deleted from the Certificate and replaced with the following:
- 4.55 Transportation Services.** Stretcher van and/or wheelchair van transportation services are **NOT COVERED**.
- S. Section **4.57, Weight Control**, is deleted from the Certificate and replaced with the following:
- 4.57 Weight Control.** Weight management programs for non-morbid obesity are **NOT COVERED** unless provided for in Section 3.34 of this Certificate or as set forth in **Exhibit 4, Preventive Services**.
- T. Section **4.58.2, Enteral Feedings/Food Supplements**, shall be deleted in its entirety and replaced with the following:
- 4.58.2 Medical Foods.** Enteral feedings/food supplements and amino acid-based elemental medical formula obtained from Non-Preferred Providers are **NOT COVERED**.
- U. Section **4.58.5, Mental Health or Substance Abuse Services Obtained From a Provider Who Does Not Participate in the PPO's Designated Behavioral Health Benefit Program**, is deleted from the Certificate in its entirety.
- V. Section **4.58.9, Ostomy Supplies**, is added to the Certificate as follows:
- 4.58.9 Ostomy Supplies.** Ostomy supplies obtained from Non-Preferred Providers are **NOT COVERED**.
- W. Section **4.58.10, Scheduled Transportation Services**, is added to the Certificate as follows:
- 4.58.10 Scheduled Transportation Services.** Scheduled transportation services obtained from Non-Preferred Providers are **NOT COVERED**.
- X. Section **4.58.11, Urological Supplies**, is added to the Certificate as follows:
- 4.58.11 Urological Supplies.** Urological supplies obtained from Non-Preferred Providers are **NOT COVERED**.
- Y. Section **4.58.12, Impacted Wisdom Teeth Services**, is added to the Certificate as follows:
- 4.58.12 Impacted Wisdom Teeth Services.** Impacted wisdom teeth services that are not obtained from Preferred Providers are **NOT COVERED**.
- Z. Section **4.58.13, Refraction Services**, is added to the Certificate as follows:
- 4.58.13 Refraction Services.** Refraction services that are not obtained from Preferred Providers are **NOT COVERED**.

AA. Section 4.59.5, **Computerized Devices and Communicative Equipment**, is deleted from the Certificate and replaced with the following:

4.59.5 Computerized Devices and Communicative Equipment. The following communicative devices and/or services are **NOT COVERED**:

- (a) Devices not specifically dedicated as speech devices (e.g., personal laptop or desktop computers, smartphones personal digital assistants (PDA's), word processing or accounting packages and programs);
- (b) Communications boards;
- (c) Multilingual modules;
- (d) Use of a speech generating device in a Member without a documented severe speech impairment;
- (e) Internet connection or other phone services;
- (f) Hardware or software used to create documents and spreadsheets;
- (g) Hardware or software used to play games or music; or
- (h) Separate charges for installation of software programs or technical support.

BB. Section 4.59.6 **Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthoses** is deleted from the Certificate and replaced with the following:

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

CC. Section 4.59.11, **Home Monitoring Equipment**, is deleted from the Certificate.

DD. Section 4.59.19, **Non-Standard Equipment or Devices**, is deleted from the Certificate and replaced with the following:

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

EE. Subsection 4.59.21, **"Replacement of Component Parts or Modification ..."** is deleted from the Certificate and replaced with the following:

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

FF. Section 4.59.22, **Specifically Listed Items, Devices and Equipment**, is amended to delete reference to:

- a) Breast pumps.

GG. Section 4.60, **Oral Nutrition Products or Supplements** is added to the Certificate as follows:

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

HH. Section 4.61, **Personal and Athletic Trainer Services** is added to the Certificate as follows:

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

- II.** Section **4.62, Services Provided in Conjunction with a Non-Covered Service** is added to the Certificate as follows:
- 4.62 Services Provided in Conjunction with a Non-Covered Service.** Any service, which would otherwise be a Covered Service under this Certificate, when provided in conjunction with the provision of a non-Covered Service, is **NOT COVERED**. Such services may include but are not limited to anesthesia or diagnostic services. This exclusion does not include Medically Necessary Covered Services incurred due to complications resulting from a Member's receipt of a non-Covered Service or General Anesthesia and Associated Medical Costs as set forth in Certificate Section 3.33.
- JJ.** Section **4.63, General Anesthesia for Temporal Mandibular Joint Disorders (TMJ)**, is added to the Certificate as follows:
- 4.63 General Anesthesia for Temporal Mandibular Joint Disorders (TMJ).** General Anesthesia for dental care rendered for (TMJ) is **NOT COVERED**.
- KK.** The following sections are deleted from Section 4 of the Certificate in their entirety:
- (a) Section 4.32, Mental Health Inpatient Professional Services;
 - (b) Section 4.33, Mental Health Inpatient Services; and
 - (c) Section 4.34, Mental Health Partial Hospitalization Services.
- LL.** Section **4.19, Experimental, Investigational or Unproven Services**, is deleted from the Certificate and replaced with the following:
- 4.19 Experimental, Investigational or Unproven Services.** Experimental, investigational or unproven services are **NOT COVERED**. This exclusion does not apply to a qualified Member's participation in an approved clinical trial for cancer or other life-threatening disease or condition.
- MM.** Section **4.64, Surrogate Services**, is added to the Certificate as follows:
- 4.64 Surrogate Services.** Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and pre-natal/delivery/post-natal services are **NOT COVERED**.
- NN.** Section **4.65, Reversal of Genital Surgery**, is added to the Certificate as follows:
- 4.65 Reversal of Genital Surgery.** Surgical procedures to reverse genital surgery are **NOT COVERED**, except as stipulated in Section 4.62, **Services Provided in Conjunction with a Non-Covered Service**.
- OO.** Section **4.66, Reversal of Surgery to Revise Secondary Sex Characteristics**, is added to the Certificate as follows:
- 4.66 Reversal of Surgery to Revise Secondary Sex Characteristics.** Surgical procedures to reverse secondary sex characteristic surgery are **NOT COVERED**, except as stipulated in Section 4.62, **Services Provided in Conjunction with a Non-Covered Service**.
- PP.** Section **4.11, Corrective Devices**, is deleted from the Certificate and replaced with the following:
- 4.11 Corrective Devices.** The purchase, fitting, or adjustment of corrective devices including but not limited to, eyeglasses, contact lenses, and hearing aids, are **NOT COVERED**, except as may be explicitly provided in Section 3.6.4 Prosthetic Devices, Section 3.13 Implanted Devices, and under the terms of the following Rider: Eyewear.

- QQ.** Section **4.5, Behavioral Services**, is deleted from the Certificate and replaced with the following:
- 4.5 Behavioral Services.** Any treatment or care related to autistic disease of childhood, hyperkinetic syndrome, intellectual disabilities, behavioral problems and intellectual disabilities, which extend beyond traditional medical management are **NOT COVERED**.
- RR.** Section **4.67** is added to the Certificate as follows:
- 4.67** Costs associated with the following are **NOT COVERED**:
- a) Group Homes;
 - b) Half-Way Houses;
 - c) Temporary Lodging Facilities;
 - d) Sober Living Home/housing.
- SS.** Section **4.68** is added to the Certificate as follows:
- 4.68 Peer Support Services.** Peer support services are **NOT COVERED** except those peer support services set forth in Exhibit 4, Preventive Covered Services.
- TT.** Section **4.51, Routine Nail Trimming**, is deleted from the Certificate and replaced with the following:
- 4.51. Routine Nail Trimming.** Except for diabetic nail trimming, routine nail trimming is **NOT COVERED**.
- UU.** Section **4.54, Sexual Dysfunction Services, Devices and Equipment**, is deleted from the Certificate and replaced with the following:
- 4.54 Sexual Dysfunction Services, Devices and Equipment.** Sexual dysfunction services, devices and equipment are **NOT COVERED**.
- VV.** Section **4.69, Hearing Services**, is added to the Certificate as follows:
- 4.69 Hearing Services.** Except as provided for in Section 3.13, Implanted Devices and Exhibit 4, routine hearing or audiometric examinations, routine hearing examinations, and services and supplies related to these items are **NOT COVERED**.
- WW.** Section **4.70, Sex-trait Modification Procedure(s)**, is added to the Certificate as follows:
- 4.70 Sex-trait Modification Procedure(s).** Sex-trait Modification Procedure(s), as defined in Section 1 (DEFINITIONS), are **NOT COVERED**.
- XX.** Section **4.71, Other Non-Covered Services** is added to the Certificate as follows:
- 4.71 Other Non-Covered Services:** including, but not limited to: barber or beauty service; disciplinary services, including truancy-related services; services that are primarily educational in nature - including, but not limited to, vocational rehabilitation, recreational therapy, educational therapy, or experiential education; guest service; intensive health coaching; testing for learning disabilities; resource coordination activity; sensitivity training; sexual surrogate programs; summer camp programs; therapeutic boarding school or transitional programs; and twelve-step model programs; Any services that are court-ordered, unless such services are otherwise covered services and medically necessary.

7. **SECTION 5. APPEAL PROCEDURE.**

- A. **SECTION 5, APPEAL PROCEDURE**, is deleted from the Certificate and replaced with the following new **SECTION 5, APPEAL PROCEDURE**:

SECTION 5. APPEAL PROCEDURE

For Covered Services Sought or Received from a Cigna Healthcare® PPO Network* Provider:

If you sought or received Covered Services from a Cigna Healthcare® PPO Network* provider and have a dispute or objection regarding an Adverse Benefit Determination made by Cigna Healthcare, you may ask Cigna Healthcare for an Appeal of that Adverse Benefit Determination. You or your representative may file an Appeal with Cigna Healthcare in writing or over the phone. To submit an appeal over the phone, please call 1-866-494-4872. To submit an appeal in writing, please mail your appeal to Cigna Healthcare, Attn: Appeals, P.O. Box 188062, Chattanooga, TN 37422-8062. You are encouraged to send any other written information to support your appeal.

**The Cigna Healthcare® PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare® PPO for Shared Administration. Cigna Healthcare is an independent company and is not affiliated with Geisinger Health Plan and its affiliates. Access to the Cigna Healthcare® PPO Network is available through Cigna Healthcare's contractual relationship with the PPO. All Cigna Healthcare products are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property Inc.*

For Covered Services Sought or Received from PPO Preferred Providers (excluding Cigna Healthcare® PPO Network* Providers):

APPEAL PROCEDURE. Requests for an appeal must be submitted **in writing** and received by the PPO within **one hundred eighty (180) days** following the Member's receipt of the notification of an Adverse Benefit Determination (an Adverse Benefit Determination is any decision made by the PPO with respect to payment or service related issues that results in a denial).

*If a Member chooses to appeal an Adverse Benefit Determination, a **written request** must be submitted to:*

Geisinger PPO
Appeal Department
100 North Academy Avenue
Danville, PA 17822-3220

At any time during any of the appeal processes outlined below, a Member may choose to designate in writing a representative to participate in the appeal process on the Member's behalf (an "Authorized Representative"). In this Section 5 of the Certificate, the definition of Member shall include a Member's Authorized Representative. The Member shall be responsible to notify the PPO in writing of such designation. The PPO has an authorization form available for the Member's use in order to designate an individual to act as the Member's Authorized Representative. This form can be obtained by calling the Customer Service Team at the telephone number indicated on the back of the Member's Identification Card.

Members have the right to provide the PPO with written comments, documents, records or other information to be considered as part of the appeal review.

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

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

Pre-Service Appeal – Not later than 30 days after the PPO receives the written request

Post-Service Appeal – Not later than 30 days after the PPO receives the written request

Urgent Care Appeal – Not later than 72 hours after the PPO receives the request

5.1 Pre-Service Appeal Procedure. A Pre-Service Appeal is a request to change an Adverse Benefit Determination for care or services that the PPO must approve, in whole or in part, in advance of the Member obtaining care or services.

A Member may request a Pre-Service Appeal in writing to the PPO. The PPO will provide a full and fair review of the appeal.

5.1.1 Pre-Service Appeal Review for Denials not based on Medical Judgment. A Pre-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member's appeal including any material submitted by the Member to the PPO. The PPO shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member's right to attend the Member Satisfaction Review Committee meeting.

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

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

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

- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;
- d) notification that the Member may request assistance with their appeal from the applicable state Office of Health Insurance Consumer Assistance; and
- e) the Member may have the right to request an external appeal review conducted by an Independent Review Organization (“IRO”) (if applicable).

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

5.2.1 Post-Service Appeal Review for Denials not based on Medical Judgment. A Post-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the Adverse Benefit Determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by the PPO or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Member’s appeal including any material submitted by the Member to the PPO. The PPO shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Member’s right to attend the Member Satisfaction Review Committee meeting.

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

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

notification of the PPO's decision no later than thirty (30) days from receipt. The written notification from the PPO shall include:

- a) the basis for the decision in easily understandable language;
- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;
- d) notification that the Member may request assistance with their appeal from the applicable state's Office of Health Insurance Consumer Assistance; and
- e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

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

- a) could seriously jeopardize the life or health of the Member, or the ability of the Member to regain maximum function as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or
- b) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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

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

- a) the basis for the decision in easily understandable language;
- b) reference to the specific PPO provisions on which the decision is based;
- c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant

to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and

- d) notification that the Member may request assistance with their Appeal from the applicable state's Office of Health Insurance Consumer Assistance; and
- e) The Member may have the right to request an external appeal review conducted by an Independent Review Organization ("IRO") (if applicable).

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

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

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

- a) The Member is or was covered under the PPO at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the PPO at the time the health care item or service was provided;
- b) The adverse benefit determination or the Final Adverse Benefit Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of the PPO (e.g., worker classification or similar determination);
- c) The Member has exhausted the PPO's internal appeal process, unless the Member is not required by applicable State or Federal regulation to exhaust the internal appeals process; and
- d) The Member has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the PPO must issue written notification to the Member. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete. To complete an incomplete request, the Member will have either the remainder of the four (4) month filing period (as detailed in Section 5.4.2) or within forty-eight (48) hours following the receipt of the notification, whichever is later.

5.4.1.2 External Review Procedure. If an external review is warranted, the Pennsylvania Insurance Department will assign an independent review organization (IRO) as required by and in accordance with all applicable State and Federal regulations. The IRO will notify the Member of acceptance for external review and will inform

the Member that they may submit in writing, within fifteen (15) business days, any additional information the Member would like the IRO to consider in the review. The IRO will perform an independent claim review and will not be bound by decisions or conclusions reached during the PPO's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- a) The Member's medical records;
- b) The attending health care professional's recommendation;
- c) Reports from appropriate health care professionals and other documents submitted by the PPO, Member, or the Member's treating Provider;
- d) The terms of the Member's PPO plan to ensure that the IRO's decision is not contrary to the terms of the PPO plan, unless the terms are inconsistent with applicable law;
- e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- f) Any applicable clinical review criteria developed and used by the PPO unless the criteria are inconsistent with the terms of the PPO plan or with applicable law; and
- g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section 5.4.2.2 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

5.4.1.3

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

- a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial);
- b) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- c) References to the evidence or documentation including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- d) A discussion of the principal reason for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision;

- e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the PPO or the Member;
- f) A statement that judicial review may be available to the Member; and
- g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

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

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

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

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

5.4.2.1 **Preliminary Review.** If the PPO determines the expedited external review request meets the requirements set forth in section 5.4.2.1, notice will be sent to the Member within twenty-four (24) hours after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

5.4.2.2 **External Review Procedure.** If an external review is warranted, the Pennsylvania Insurance Department will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The PPO will provide all the necessary documents and information considered in making the Final Adverse Benefit Determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.2.2. In reaching a decision, the IRO will

review the claim de novo and shall not be bound by any decisions or conclusions reached during the PPO's internal appeal procedures.

5.4.23 Notice of the Final External Review Decision. The IRO will provide notice of the final external review decision in accordance with section 5.4.2.3 (a) through (g) as expeditiously as the Member's medical condition requires, but in no event later than seventy-two (72) hours after the IRO receives a request for an expedited external review.

8. SECTION 6 - ELIGIBILITY.

A. Sections **6.2 through 6.2.6** are deleted from the Certificate and replaced with the following:

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

- a) The spouse of a Subscriber under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania.
- b) A Subscriber's child (married or unmarried) who has not yet attained the age of twenty-six (26) is eligible for enrollment as follows:
 - 1) Eligible children of the Subscriber include:
 - i) natural children and
 - ii) stepchildren.
 - 2) Eligible children of the Subscriber and/or the Subscriber's spouse who is an enrolled Member under this PPO include:
 - i) children legally placed for adoption;
 - ii) children awarded coverage pursuant to an order of court;
 - iii) legally adopted children; and
 - iv) foster children placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Such children may live within or outside the Service Area but benefits will be limited to those as set forth in this Certificate.

Eligibility shall cease for a dependent child on the last day of the month in which the dependent child becomes age 26 (except for disabled dependent children).

Coverage for a Family Dependent will become effective only if the Subscriber has Family Coverage and the applicable premium is duly paid.

6.2.1 Intentionally left blank.

6.2.2 New Spouse. A newly married Subscriber may arrange for Family Coverage by enrolling his or her spouse in the PPO within sixty (60) days of marriage. Coverage of the spouse under this Certificate shall be effective as of the date of marriage if the Subscriber's coverage was in effect on that date. Premiums for such continued coverage of a spouse shall be payable from the date of marriage. No Evidence of Insurability shall be required.

6.2.3 Newborn Child(ren).

6.2.3.1 Coverage from Birth to Thirty-One (31) Days. A newborn child, whether natural born, adopted, or placed for adoption, of the Subscriber or eligible Family Dependent is covered

as a Member under this Certificate from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

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

- a) (i) The newborn child must be a child who is a natural born, adopted or legally placed for adoption, or under the Legal Guardianship or Legal Custodianship of the Subscriber or the Subscriber's eligible spouse; and
- (ii) The Subscriber must contact their Employer Group's personnel or human resources department within sixty (60) days from the date of the newborn's birth to complete the appropriate enrollment forms for continued coverage of the newborn under this Certificate.

OR

- b) (i) The newborn child must be a child who is a natural born, adopted or legally placed for adoption, or under the Legal Guardianship or Legal Custodianship of the Subscriber or the Subscriber's eligible spouse; and
- (ii) within sixty (60) days from the newborn's birth, the newborn's parent(s), Legal Guardian, or Legal Custodian may convert to a separate individual policy, offering similar benefits to this Certificate, on behalf of the newborn.

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

6.2.4 Adopted Child. A legally adopted child or a child for whom a Subscriber or the Subscriber's eligible dependent spouse is a court appointed Legal Guardian or Legal Custodian and who meets the definition of a Family Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a Subscriber's coverage becomes effective and the Subscriber must make a written request for coverage within sixty (60) days of the date the child is adopted or placed with the Subscriber or the Subscriber's eligible dependent spouse for adoption.

An adopted child, or a child placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse is automatically covered under this Certificate for thirty-one (31) days from the date of adoption or date of placement for adoption. To continue coverage, a written Enrollment Application for addition to Family Coverage (or a change from Single to Family Coverage) must be submitted to the PPO within sixty (60) days of the date of adoption or date the child was placed for adoption with the Subscriber or the Subscriber's eligible dependent spouse. The PPO will require documentary proof (i.e., official court documents) evidencing legal adoption or placement for adoption. Premiums for such coverage of an adopted child or child placed for adoption shall be payable from the date of coverage.

6.2.5 Intentionally left blank.

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

- a) the child is incapable of self-sustaining employment by reason of disability resulting from intellectual disabilities or a physical disability and the child became so prior to the attainment of age nineteen (19); and
- b) the child is chiefly dependent (more than 50%) upon the Subscriber for support and maintenance.

In order to continue coverage of a disabled dependent child, the Subscriber must provide evidence to the PPO of the child's incapacity and dependency within sixty (60) days of the date the child's coverage would otherwise terminate. The PPO may periodically require documentary proof of such disability and dependency, but no more frequently than every six (6) months for the first two (2) years, and annually thereafter, from the date of the first request for continued Family Coverage on behalf of the disabled dependent child, or from the date on which the PPO is first notified of such disability and dependency, whichever is earlier.

B. Section **6.2.7, Students**, is deleted from the Certificate.

C. Section **6.2.7.1 Students-Military Duty**, is renumbered as Section **6.2.7, Military Duty**, and the following definition of full-time student shall be included with this Section **6.2.7**:

A full-time student under this Section shall mean

- (i) a dependent child who is eligible for health insurance coverage under their parents' insurance policy, **and**
- (ii) who is either a high school student or enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than twelve (12) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

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

D. Section **6.2.7.2, Continuing Coverage of Full-Time Students on Medical Leave**, is deleted from the Certificate.

E. Section **6.2.8, Noncustodial Children**, is deleted from the Certificate and replaced with the following:

6.2.8 Noncustodial Children. A noncustodial child is a natural child or adopted child of the Subscriber for whom the Subscriber is obligated to provide health care coverage through a court order or qualified medical support order (collectively referred to as "Order").

(a) The PPO will require documentary proof (i.e., official court order or qualified medical support order) evidencing the obligation of the Subscriber to provide health care coverage together with a written application to the PPO for membership of such child.

(b) The written application for membership must be received by the PPO within sixty (60) days of the PPO's receipt of the Order. A noncustodial child will not be enrolled without timely receipt by the PPO of a written application.

(c) The effective date of membership in the PPO for a noncustodial child will be determined as follows:

(i) If an Order is received by the PPO within 60 days of the date of the Order AND the written application has been received by the PPO in accordance with subsection (b) above, then the effective date of coverage for the noncustodial child under the PPO will be the effective date of coverage as directed in the Order.

(ii) If the Order is received by the PPO more than 60 days after the date of the Order AND the written application has been received by the PPO in accordance with subsection (b) above, then the effective date of coverage for the noncustodial child under the PPO shall be effective the first day of the next calendar month following the PPO's receipt of the Order.

(d) The Subscriber shall notify the PPO of the name and address of the custodial parent in order to allow the PPO to provide information to and make payment on claims to the custodial parent as required under the laws of the Commonwealth of Pennsylvania.

(e) The PPO may not disenroll or eliminate coverage of any child unless the PPO is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health care coverage through another insurer which will take effect no later than the effective date of such disenrollment.

F. Section 6.6.2 Non-Open Enrollment Period Application is deleted from the Certificate and replaced with the following:

6.5.2 Non-Open Enrollment Period Application. Any individual who first satisfies the eligibility requirements and who makes written application for membership at a time other than an Open Enrollment Period but within sixty (60) days of initially attaining eligibility shall become effective on the day following the last day of coverage with the prior health benefit program, except for:

- a) newly married spouses, newborns, adopted children, foster children, or children placed for adoption, whose dates of coverage are established by law; and noncustodial children of a Subscriber when the Subscriber receives an official court order or a qualified medical support order to provide health care coverage for such noncustodial child(ren).
- b) As otherwise set forth in the Group Master Policy when the Group Master Policy is modified by the Group. Coverage for individuals who fail to enroll during the Open Enrollment Period or within sixty (60) days of initially attaining eligibility shall NOT be eligible to enroll until the next Open Enrollment Period.

G. Section 6.7 Manner of Enrollment is deleted from the Certificate and replaced with the following:

6.7 Manner of Enrollment. During an Open Enrollment Period or on initially becoming eligible at any other time, an eligible person may enroll or be enrolled in the Plan by submitting a completed Enrollment Application on forms provided by the Plan (or provided by the Group if approved by the Plan). No eligible person will be refused enrollment within sixty (60) days of first attaining eligibility, during an Open Enrollment Period, or as a result of a special enrollment period.

H. Section 6.8 Failure to Enroll Or Be Enrolled When Eligible is deleted from the Certificate and replaced with the following:

6.8 Failure to Enroll Or Be Enrolled When Eligible. Any eligible individual who fails to enroll or be enrolled during an Open Enrollment Period or within sixty (60) days after first becoming eligible shall not be permitted to enroll until the next Open Enrollment Period unless they meet the rules for special enrollment periods.

I. Section 6.8.1, Special Enrollment Period – Loss of Eligibility Status, is deleted from the Certificate and replaced with the following:

6.8.1 Special Enrollment Period – Eligibility and Qualifying Events.

- a) An individual and any dependent(s) each are eligible for special enrollment in any benefit package under the PPO (subject to PPO eligibility rules) if (i) the individual and their dependents are otherwise eligible to enroll in the benefit package; (ii) when coverage under the PPO was previously offered, the individual and their dependents had coverage under any group health plan or health insurance coverage; (iii) the individual declined enrollment, in writing, for himself and any family dependent stating that the coverage under another group health plan or health insurance coverage was the reason for declining enrollment; and (iv) loss of eligibility under the other group health benefit program was as a result of one of the following qualifying events:
 - i) termination of employment,
 - ii) reduction in the number of hours of employment,
 - iii) termination of other program's coverage,
 - iv) termination of contributions toward the premium made by the Group,
 - v) death of a spouse, divorce, or legal separation,
 - vi) exhaustion of the COBRA or Mini-COBRA maximum period of coverage (for COBRA or Mini-COBRA eligible Groups),
 - vii) no longer working or residing in the service area when the other group health benefit program (such as an HMO) does not provide benefits to an individual who no longer works or resides in the service area, or
 - viii) loss of dependent status.
- b) An individual and a new dependent each are eligible for special enrollment in any benefit package under the PPO (subject to PPO eligibility rules) if the individual and their new dependent are otherwise eligible to enroll in the benefit package and the individual gains the new dependent or becomes a new dependent through marriage, birth, adoption or placement for adoption or foster care.

6.8.1.1 **Length of Special Enrollment Period.** A qualified individual or his or her dependent has sixty (60) days from the date of a qualifying event to apply for enrollment in this PPO.

J. Section **6.8, Pre-Existing Condition Exclusion** and sub-sections **6.8.1, Exceptions to Pre-Existing Condition Exclusion** and **6.8.2, Creditable Coverage** are deleted from the Certificate.

K. Section **6.12, Notice of Ineligibility**, shall be deleted from the Certification and replaced with the following:

6.12 Notice of Ineligibility. It shall be the Subscriber's responsibility to notify the Group or the PPO of any changes which will affect the Subscriber's eligibility or that of a Family Dependent for Covered Services or benefits under this Certificate within sixty (60) days of the event.

9. SECTION 7 – PAYMENT PROVISIONS.

A. Section **7.2.1** is added to the Certificate as follows:

7.2.1 Adjustment of Premium based on Class. The PPO reserves the right to change the premium on a class basis.

B. Section **7.4, Grace Period**, shall be deleted from the Certificate and replaced with the following:

7.4 Grace Period. If the Group, or its agent on behalf of a Subscriber, fails to pay a premium within sixty (60) days or the time period as set forth on the Group Master Policy after it becomes due, this Certificate shall be terminated pursuant to Section 8.6 and no Member will be entitled to further benefits after the last day of the grace period except as set forth in Section 8.9. The Group or its agent on behalf of a Subscriber shall be responsible for payment of the premium for the time coverage was in effect during

the grace period. The Subscriber shall be responsible to pay any required Copayment, Deductible or Coinsurance amounts incurred by the Subscriber or any Family Dependent during the grace period.

10. SECTION 8 - GENERAL PROVISIONS.

A. Section **8.2.7, Right of Recovery**, is deleted from the Certificate and replaced with the following:

8.2.7 Right of Recovery. If the amount of the payment made by This Plan is more than it should have paid under this COB provision, or if it has provided Covered Services which should have been paid by the Primary Plan, This Plan may recover the excess or the reasonable cash value of the Covered Services as applicable, from one or more of:

- a) the persons it has paid;
- b) insurance companies; or
- c) other organizations.

B. Section **8.2.10** is added to the Certificate as follows:

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

C. Section **8.3, Subrogation**, is deleted from the Certificate and replaced with the following:

8.3 Subrogation and Reimbursement Rights.

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

For purposes of this Section 8.3, the term "Responsible Third Party" shall include, but not be limited to, any (i) person or entity, including any insurance company or indemnifier, employer in a workers' compensation case or other matter alleging liability, person or entity who is or may be obligated to pay benefits to the Member (including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage, workers' compensation coverage, other insurance carriers or third party administrators), (ii) person or entity against whom the Member may have a claim for professional malpractice, or any other equitable or legal liability theory, or (iii) health benefits plan or other third party, which has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to a Member for an injury or illness, in each case, where the PPO provided medical care or benefits to, or incurred expenses for or on behalf of, the Member in connection therewith.

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

Subrogation Example. The Member is injured in an accident that is not the Member's fault and receives benefits under the PPO to cover the Member's injuries. Under this subrogation provision, the PPO has the right to take legal action in the Member's name against the individual who caused the accident and that individual's insurance carrier to recover the cost of those benefits.

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

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

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

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

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

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

D. Section **8.6.1, Failure to Pay**, is deleted from the Certificate in its entirety and replaced with the following:

8.6.1 Failure to Pay By the Group.

- At least 30 days prior to the conclusion of the grace period as described in Section 7.4 (Grace Period), the PPO shall provide written notice to the Group of Group's failure to pay premium.
- At least 15 days prior to the conclusion of the grace period as described in Section 7.4 (Grace Period), the PPO shall provide separate written notices to both the Group and the Subscriber.
 - The notice to Group shall be a final notice of termination due to non-payment of premium and include, among other things, the amount of premium due, the due date and notice that employee coverage will be terminated if premium is not paid by such date.
 - The notice to Subscriber shall provide notice of the Group's failure to pay premium and what will happen to the Subscriber's coverage if the Group fails to pay premium.
- Following the conclusion of the grace period as described in Section 7.4 (Grace Period), if the Group fails to pay any amount due the PPO, for the benefits of the Subscriber or any Family Dependents, coverage shall terminate for the Subscriber and all Family Dependents. The effective date of the termination shall be the end of the grace period.
- A Member whose coverage is terminated due to the Group's failure to pay pursuant to this Section may be eligible for conversion to individual, direct payment coverage, provided that application is made within thirty-one (31) days of the date of notification of termination and subject to payment of premiums as billed within thirty-one (31) days of the date such bill is issued.

E. Sections **8.6.2.1, Fraud or Material Misrepresentation by the Group** and **8.6.2.2, By the Member**, are deleted from the Certificate and replaced with the following:

8.6.2.1 By the Group. In the event the Group makes an intentional misrepresentation of a material fact for the purpose of obtaining coverage for a person who does not meet eligibility requirements for coverage in the Group, coverage shall terminate subject to fifteen (15) days written notice to the Group and the Subscriber. For termination of coverage with a retroactive effect, thirty (30) days advance written notice will

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

8.6.2.2 By the Member. If it is proven that the Member attempted or committed fraud under this Certificate to obtain benefits or payment or if the Member makes an intentional misrepresentation of a material fact in the application for coverage under this Certificate, the Member's coverage will be terminated subject to fifteen (15) days written notice to the Subscriber and the Group. For termination of coverage with a retroactive effect, thirty (30) days advance written notice will be provided to the Subscriber. This decision may be appealed through the PPO's established Complaint procedure as set forth in Section 5 of this Certificate.

F. Section **8.6.7, Disruptive Behavior**, is deleted from the Certificate in its entirety.

G. Section **8.6.8, Conversion Privileges**, is deleted from the Certificate and replaced as follows:

8.6.8 Conversion Privileges. If a Member's coverage terminates for any reason other than non-payment of a required contribution and the Member has been continuously insured under the Certificate for at least three (3) months immediately prior to termination, the Member shall be eligible for individual conversion coverage (referred to as "Conversion Coverage").

A Member is not entitled to Conversion Coverage if other similar group coverage will replace this Certificate within thirty-one (31) days, if coverage terminated under the Certificate because the Member failed to pay required premium contributions, or if the Member is or could be covered by Medicare. Members who are eligible to continue Group coverage under the provisions of COBRA or Mini-COBRA (for COBRA and Mini-COBRA eligible Groups) are eligible for conversion coverage when their COBRA or Mini-COBRA eligibility for Group coverage expires.

The PPO will give the Member written notice of the conversion privilege within fifteen (15) days before or after the date of termination of coverage. The Member must apply for Conversion Coverage and pay the applicable premiums within thirty-one (31) days after the termination of coverage under the Certificate, or within fifteen (15) days after the PPO provides the Member notice of conversion rights, whichever is later.

The Member may enroll in Conversion Coverage without a medical examination. The first premium payment must be received before Conversion Coverage will be put in force. Conversion Coverage shall begin the day after termination of coverage under the Certificate.

H. Section **8.6.9, Discontinuation of this Certificate by Geisinger Quality Options, Inc.**, is added to the Certificate as follows:

8.6.9 Discontinuation of this Certificate by Geisinger Quality Options, Inc.__Geisinger Quality Options, Inc. may elect to discontinue offering this Certificate, under which the Subscriber and any Family Dependents are enrolled, from the large group market, in accordance with applicable State law provided:

(i) Geisinger Quality Options, Inc. provides written notice, in a form and manner specified by the Pennsylvania Insurance Department or the Secretary of Health and Human Services, to each Group and to all Subscribers and their Family Dependents covered under this Certificate, of the discontinuation at least ninety (90) calendar days before the date of coverage will be discontinued; and

(ii) Geisinger Quality Options, Inc. offers to each Group provided this Certificate the option, on a guaranteed availability basis, to purchase any other health insurance coverage currently being offered by Geisinger Quality Options, Inc., in the large group market; and

(iii) in exercising the option to discontinue this Certificate and in offering the option of coverage under paragraph (ii) of this section, Geisinger Quality Options, Inc. acts uniformly without regard to the claims experience of those Groups, Subscribers or Family Dependents, as applicable, or any health status-related factor relating to any Subscribers or Family Dependents covered or new participants or beneficiaries who may become eligible for such coverage.

I. Section 8.6.10, Discontinuation of Coverage by Geisinger Quality Options, Inc., is added to the Certificate as follows:

8.6.10 Discontinuation of Coverage by Geisinger Quality Options, Inc. in the Market. For purposes of this subsection 8.6.10, Market shall be defined to mean the Commonwealth of Pennsylvania.

Geisinger Quality Options, Inc. may elect to discontinue offering all health insurance coverage in the large group Market, in accordance with applicable State law provided:

(i) Geisinger Quality Options, Inc. provides notice in writing to the Pennsylvania Insurance Department and to each Group (and to all Subscribers and their Family Dependents covered under the coverage) of the discontinuation at least one hundred eighty (180) calendar days prior to the date the coverage will be discontinued; and

(ii) all health insurance policies issued or delivered for issuance in the large group Market are discontinued and not renewed.

J. Section 8.7.2, regarding Reinstatement, is deleted from the Certificate and replaced with the following:

8.7.2 At the PPO's sole discretion, the PPO may reinstate a Member whose coverage has been terminated:

- a) for loss of eligibility, if the Member recaptures eligibility status and continues to satisfy the eligibility requirements; or
- b) at the Subscriber's request, if the Subscriber or the Group notifies the PPO within sixty (60) days of the date of the initial request to terminate that termination is no longer desired.

K. Sections 8.14.1, Claims and Reimbursement, and 8.14.2, Reimbursement, are deleted and replaced with the following:

8.14 Claims and Reimbursement.

8.14.1 Claims and Claim Form. The PPO will not be liable under this Certificate unless proper notice is furnished to the PPO that Covered Services have been rendered to a Member as follows:

- a.) **Preferred Provider Claims.** The timely filing of claims is the responsibility of the Preferred Provider, and the Member will have no payment responsibility for such claim which is not filed on a timely basis by the Preferred Provider.
- b.) **Non-Preferred Provider Claims.** Members are required to file a claim for all services rendered by a Non-Preferred Provider. No payment will be made for any claims filed by a Member for services rendered by a Non-Preferred Provider unless the Member gives written notice of such claim to the PPO within one (1) year of the date of service.

To file a claim, the Member should call the PPO at the telephone number listed on the Member Identification Card to obtain a claim form. Section A of the claim form must be signed by the Member before the PPO will issue payment to a provider or reimburse the Member for services received under this Certificate. The Member must complete a claim form for services rendered by a Non-Preferred Provider and submit it, together with an itemized bill, to the following address:

Geisinger Quality Options, Inc.
P.O. Box 160
Glen Burnie, MD 21060

If a claim form is not received by the Member within fifteen (15) days of request to the PPO, the Member may provide an itemized bill from the Provider containing the following information, in writing, in lieu of the claim form:

- 1.) Full name of Member for whom the services were rendered.
- 2.) Date(s) of service.
- 3.) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
 - a. Procedure/Service codes (and Modifiers)
 - b. Diagnosis codes
 - c. Location code
- 4.) Charges for each service.
- 5.) Servicing Provider/facility and address. If available, telephone number and Provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Quality Options, Inc.
P.O. Box 160
Glen Burnie, MD 21060

Proof of Loss. Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof of loss within such time, provided such proof of loss is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof of loss is otherwise required.

8.14.2 Time of Payment of Claims/Reimbursement. In the event a Member is required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, the PPO will reimburse the Member by check immediately upon receipt of written proof of claim set forth under Section 8.14.1 of this Certificate. A receipt that includes the Member's Insurance ID Number (displayed on the Member's Identification Card) must be submitted to the PPO as soon as possible, but in no event later than one (1) year from the date of the service. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Certificate.

L. Section 8.22, Notices is deleted from the Certificate and replaced with the following:

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

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

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

M. Section **8.24, Time Limit on Certain Defenses**, is deleted and replaced with the following:

8.24 Time Limit on Certain Defenses.

- 8.24.1 **Material Misstatements.** Material misstatements made by the applicant in connection with the Certificate will, at the option of the PPO, permit the PPO to void the Certificate or deny claims, provided such material misstatement is discovered by the PPO within three (3) years of the date of issue of the Certificate.
- 8.24.2 **Intentional Misrepresentation of a Material Fact.** Intentional misrepresentation of a material fact made by the applicant in connection with the Certificate will, at the option of the PPO, render the Certificate void from inception, provided such intentional misrepresentation of a material fact is discovered by the PPO within three (3) years of the date of issue of the Certificate.

N. Section **8.27, Certificate of Creditable Coverage**, is deleted from the Certificate.

O. Section **8.31.10, Fraud and Abuse**, is added to the Certificate as follows:

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

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

Examples of fraud and abuse are:

Examples of Fraud

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

Examples of Abuse

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

P. Section **8.32, Headings**, is added to the Certificate as follows:

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

Q. Section **8.33, Non-Discrimination**, is added to the Certificate as follows:

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

R. Section 8.34, **Assignment of Benefit to Providers**, is added to the Certificate as follows:

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

11. EXHIBITS

A. **Exhibit 1 – GEISINGER PPO WITH NO REFERRAL SERVICE AREA shall be renamed as Exhibit 1A and** shall be effective as of the effective date of this Amendment.

B. The Certificate is amended to include the Exhibits listed below:

Exhibit 1B - Supplementary Counties included in the Geisinger Coverage Network

Exhibit 1C - Supplementary Health Care Providers Included in the Geisinger Coverage Network

Exhibit 3 - Precertification List

Exhibit 4 – Preventive Services

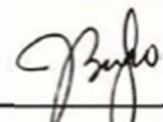
12. OTHER

A. This Amendment shall be effective for the Benefit Period beginning on or after April 1, 2026.

B. If any provisions of the Subscription Certificate are inconsistent with the terms of this Amendment, the terms of this Amendment shall prevail.

C. Except as herein amended, the Subscription Certificate shall remain in full force and effect.



Jeremy Gaskill
President
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220

John B. Bulger, DO, MBA
Chief Medical Officer
Geisinger Quality Options, Inc.
100 North Academy Avenue
Danville, PA 17822-3220

Exhibit 1A
GEISINGER CHOICE PPO
SERVICE AREA

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

Exhibit 1B
Supplementary Counties included in the Geisinger Coverage Network*

Pennsylvania

Bucks
Chester,
Delaware
Montgomery
Philadelphia

* See definition of “Geisinger Coverage Network” located in Section 1.

Exhibit 1C
Supplementary Health Care Providers Included in the Geisinger Coverage Network*

Guthrie Clinic locations in NY and PA

Jefferson Health / Lehigh Valley Health Network locations in NJ

Johns Hopkins, MD

Our Lady of Lourdes Hospital, NY

St. Luke's locations in NJ

Shriners Hospital locations in Tampa, FL; Boston, MA; Erie, PA; and Philadelphia, PA

* See definition of "Geisinger Coverage Network" located in Section 1.

Exhibit 3
Precertification List

The following (A) services and/or supplies or (B) agents and/or medications require Precertification as described in Section 2. **Please note those items with an asterisk (*) are not covered when provided by Non-Preferred.**

A. Services and/or Supplies Requiring Precertification:

1. Ambulance Transport Service (Non-Emergent)
2. Blepharoplasty (plastic surgery of the eyelids)
3. Breast Reduction/Reconstruction – unrelated to previous mastectomy for Breast Cancer
4. Bronchial Thermoplasty
5. Cardiac Devices: pacemaker, wearable and implantable defibrillator, ventricular assist device, left atrial appendage closure device, mobile cardiovascular telemetry, implantable loop recorder
6. Cardiac Nuclear Medicine
7. Cardiac Procedures: ablation, arrhythmia induction and mapping, angioplasty, stent, catheterization, transcatheter aortic valve replacement, transcatheter mitral valve repair, patent foramen ovale and atrial septal defect closure, revascularization, aortic repair
8. Comparative Genomic Hybridization (CGH) or Chromosomal Microarray Analysis (CMA) for Evaluation of Developmental Delay*
9. Deep Brain Stimulation
10. Durable Medical Equipment (DME)*
11. Dorsal Column Stimulation (spinal column stimulation)
12. Electrical and Electromagnetic Stimulation to promote wound healing
13. Endobronchial Valve
14. Extraction of Teeth and Alveoloplasty (limited to extractions performed by an oral surgeon that are required prior to organ transplantation, cardiac or radiation procedures)
15. Fetal Surgery (surgery on the unborn child)
16. Gastric Electrical Stimulation
17. Intentionally Left Blank
18. Genetic Susceptibility Cancer Panels
19. Genetic Testing for Mitochondrial Disorders
20. Health Care Services Associated with Non-Covered Services (such as anesthesia related services to non-covered dental extractions)
21. Home Health Care
22. Inpatient (planned) hospital Admissions
23. Inpatient (urgent) hospital Admissions
24. Hospital Observation over 23 hours
25. Intercostal Nerve Block
26. Interventional Pain Management
27. Intraosseous Basivertebral Nerve Ablation
28. Intrathecal Infusion Pump
29. Lung Volume Reduction Surgery
30. Magnetic Esophageal Sphincter Augmentation (LINX)
31. Mental Health and Substance Use Services:
 - i. Inpatient Services.
 - ii. Non-Hospital Residential Treatment Services

- iii Precertification is required for the following non-routine outpatient services:
 - Partial Hospitalization Services
 - Intensive outpatient program treatment
 - Outpatient electro-convulsive treatment
 - Psychological testing and Neuropsychological testing
 - Applied Behavioral Analysis (ABA)
(No Precertification for ABA services is required for a Member with an autism spectrum disorder diagnosis.)
 - Transcranial Magnetic Stimulation (TMS)
- 32. Molecular Profiling of Malignant Tumors to Identify Targeted Therapies
- 33. Multi-gene Expression Assay for Predicting Recurrence in Colon Cancer *
- 34. Musculoskeletal Procedures of the shoulder, hip, knee, spine and ankle
- 35. Non Emergency Outpatient Radiology (CT, Echocardiography, MRI, MRA, PET, Nuclear Cardiology, SPECT)
- 36. Non-Invasive Home Ventilator
- 37. Non-Wearable Automatic External Defibrillator
- 38. Nutritional Supplements*
- 39. Obesity Surgery***
- 40. Orthognathic Surgery (including, but not limited to mandibular and maxillary osteotomies)
- 41. Outpatient Rehabilitation Services (occupational, physical or speech therapy) - For non-back/neck related pain therapy, Precertification is only required when services are provided by Non-Preferred Providers. **NOTE:** Back/neck related pain therapy requires Precertification when services are provided by either a Preferred or Non-Preferred Provider.
- 42. Percutaneous Electrical Nerve Field Stimulation (PENFS)
- 43. Proton Beam Radiation
- 44. Radiation Oncology
- 45. Restorative or Reconstructive Surgical Procedures (except for a Medically Necessary mastectomy as set forth in the Policy which is not subject to Precertification)
- 46. Rhinoplasty as stand-alone procedure or Rhinoplasty with or without major septal repair in conjunction with other planned Medically Necessary surgeries
- 47. Septoplasty as stand-alone procedure/Septoplasty in conjunction with other planned Medically Necessary surgery
- 48. Skilled Nursing Facility Admission
- 49. Speech Generating Devices*
- 50. Suprascapular Nerve Block
- 51. Sympathetic Nerve Block
- 52. Termination of Pregnancy (Abortion)
- 53. Transoral Incisionless Fundoplication
- 54. Transplant evaluation services (pre-transplant services) and surgical transplantation of organs, bone marrow or stem cells. *
- 55. Tumor Treatment Fields (Optune)
- 56. Vagal Nerve Stimulation (electrical stimulation for seizure control)
- 57. Varicose Vein Procedures (including injection of sclerosing solution into varicose leg veins and vein stripping)
- 58. Vertical Expandable Titanium Rib
- 59. Whole Exome Sequencing

Agents and/or Medications Requiring Precertification:

1. Abecma™ (idecabtagene vicleucel)
2. Abilify Asimtufii™ (aripiprazole)
3. Abilify Maintena™ (aripiprazole)
4. Abraxane™ (paclitaxel protein-bound particles)
5. Actemra IV™ (tocilizumab)
6. Adakveo™ (crizanlizumab-tmca)
7. Adcetris™ (brentuximab vedotin)
8. Adstiladrin™ (nadofaragene Firadenov-vncg)
9. Aduhelm™ (aducanumab-avwa)
10. Adzynma™ (ADAMTS13, recombinant-krhn)
11. Ahzantive™ (aflibercept-mrbb)
12. Akynzeo™ IV (fosnetupitant/palonosetron)
13. Aldurazyme™ (laronidase)
14. Aliqopa™ (copanlisib)
15. Alpha 1-Antitrypsin Inhibitor Therapy
16. Altuviiiio™ (antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl)
17. Alyglo™ (immune globulin)
18. Ameluz™ (aminolevulinic acid)
19. Amondys 45™ (casimersen)
20. Amtagvi™ (lifleucel)
21. Amvuttra™ (vutrisiran)
22. Andexxa™ (andexanet alfa)
23. Anjeso™ (meloxicam injection)
24. Anktiva™ (nogapendekin alpha inbakicept-pmln)
25. Aphexda™ (motixafortide)
26. Aponvie™ (aprepitant)
27. Aralast™ (human alpha₁-proteinase inhibitor)
28. Aranesp™ (darbepoetin alfa)
29. Arexvy™ (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection)
30. Aristada™ (aripiprazole lauroxil)
31. Aristada Initio™ (aripiprazole lauroxil)
32. Arranon™ (nelarabine)
33. Arzerra™ (ofatumumab)
34. Asceniv™ (immune globulin)
35. Aucatzyl™ (obecabtagene autoleucel)
36. Aved™ (testosterone)
37. Avsola™ (infliximab-axxq)
38. Avycaz™ (ceftazidime/avibactam)
39. Azedra™ (iodine i-131 iobenguane, diagnostic, 1 millicurie)
40. Bavencio™ (avelumab)
41. Baxdela™ IV (delafloxacin)

42. BeleodaqTM (belinostat)
43. BenlystaTM (belimumab)
44. BeovuTM (brolucizumab)
45. BeqvezTM (fidanacogene elaparvovec-dzkt)
46. BerinertTM (C1 esterase inhibitor)
47. BesponsaTM (injection, inotuzumab ozogamicin)
48. Bevacizumab (avastin)
49. BeyfortusTM (nirsevimab)
50. BivigamTM (intravenous immune globulin)
51. BizengriTM (zenocutuzumab-zbco)
52. BkembvTM (eculizumab-aeeb)
53. BlincytoTM (blinatumomab)
54. BonivaTM IV (ibandronate sodium)
55. BoruzuTM (bortezomib)
56. BotoxTM (botulinum toxin A and B)
57. Botulinum Toxin and Derivatives
58. BreyanziTM (lisocabtagene maraleucel)
59. BrineuraTM (injection, cerliponase alfa)
60. BriumviTM (ublrituximab-xiyy)
61. ByoovizTM (ranibizumab-nuna)
62. Cabazitaxel
63. CarimuneTM NF (intravenous immune globulin)
64. CarvyktiTM (ciltacabtagene autoleucel)
65. CasgevyTM (exagamglogene autotemcel)
66. CerezymeTM (imiglucerase)
67. Cimerli (ranibizumab-eqrn)
68. CimziaTM (certolizumab pegol)
69. CinqairTM (reslizumab)
70. CinryzeTM (C1 esterase inhibitor)
71. CinvantiTM (aprepitant) ClolarTM (clofarabine)
72. ClolarTM (clofarabine)
73. Columvi (glofitamab-gxbm)
74. CoselaTM (trilaciclib)
75. CosentyxTM (secukinumab)
76. CresembaTM IV (isavuconazonium sulfate)
77. CrysvidaTM (burosumab-twza)
78. CutaquigTM (immune globulin subcutaneous)
79. CuvitruTM (subcutaneous immune globulin)
80. CyramzaTM (ramucirumab)
81. DalvanceTM (dalbavancin)
82. DanyelzaTM (naxitamab-gqgk)
83. DarzalexTM (daratumumab)
84. Darzalex FasproTM (daratumumab/hyaluronidase)
85. DatrowayTM (datopotamab deruxtecan-dlnk)
86. DaxxifyTM (daxibotulinumtoxinA-lanm)

87. Dextenza™ (dexamethasone lacrimal ophthalmic insert)
88. Durysta™ (bimatoprost intraocular implant)
89. Dysport™ (Botulinum toxin Type A)
90. Elahere™ (mirvetuximab soravtansine-gynx)
91. Elaprase™ (idursulfase)
92. Elelyso™ (taliglucerase alfa)
93. Elevidys™ (delandistrogene moxeparvovec-rokl)
94. Elfabrio™ (pegunigalsidase alfa-iwxj)
95. Elitek™ (rasburicase)
96. Elrexfo™ (elranatamab-bcmm)
97. Elzonris™ (tagraxofusp-erzs)
98. Empaveli™ (pegcetacoplan)
99. Empliciti™ (elotuzumab)
100. Enhertu™ (fam-trastuzumab deruxtecan-nxki)
101. Enjaymo™ (sutimlimab-jome)
102. Entyvio™ (vedolizumab)
103. Enzeevu™ (aflibercept-abzv)
104. Epkinly™ (epcoritamab-bysp)
105. Epogen™ (epoetin alfa)
106. Eraxis™ (anidulafungin)
107. Erythropoietin and Darbepoetin Therapy
108. Erzofri™ (paliperidone palmitate)
109. Evenity™ (romosozumab-aqqg)
110. Evkeeza™ (evinacumab-dgnb)
111. Exondys 51™ (eteplirsen)
112. Eylea™/Eylea™ HD (aflibercept)
113. Fabrazyme™ (agalsidase beta)
114. Fasenra™ Prefilled Syringes (benralizumab)
115. Fensolvi™ (leuprolide)
116. Fetroja™ (cefiderocol)
117. Flebogamma™/Flebogamma™ DIF(intravenous immune globulin)
118. Flolan™ (epoprostenol)
119. Fulphila™ (pegfilgrastim-jmdb)
120. Fyarro™ (sirolimus protein-bound particles)
121. Fylneta™ (pegfilgrastim-pbbk)
122. Gamifant™ (emapalumab-lzsg)
123. Gammagard Liquid™ (subcutaneous/intravenous immune globulin)
124. Gammagard S/D™ (intravenous immune globulin)
125. Gammplex™ (intravenous immune globuline)
126. Gamunex-C™/Gammaked™ (subcutaneous/intravenous immune globulin)
127. Ganciclovir Sodium™
128. Gazyva™ (obinutuzumab)
129. Gel-One™ (hyaluronan or derivative)
130. GenVisc™ 850 (hyaluronan or derivative)

131. Givlaari™ (givosiran)
132. Glassia™ (human alpha1-proteinase inhibitor)
133. Granix™ (tbo-filgrastim)
134. Halaven™ (eribulin mesylate)
135. Hemgenix™ (etranacogene dezaparvovec-drlb)
136. Hemlibra™ (injection, emicizumab-kxwh)
137. Hepzato Kit™ (melphalan/hepatic delivery system [HDS])
138. Hizentra™ (subcutaneous immune globulin)
139. Hyalgan™ (hyaluronate sodium)
140. Hymovis™ (hyaluronan or derivative)
141. Hyqvia™ (immune globulin/hyaluronidase)
142. Igalmi™ (dexmedetomidine)
143. Ilaris™ (canakinumab)
144. Ilumya™ (tildrakizumab-asmn)
145. Iluvien™ (fluocinolone acetonide)
146. Imdelltra™ (tarlatamab-dlle)
147. Imfinzi™ (durvalumab)
148. Imjudo™ (tremelimumab-actl)
149. Imlygic™ (talimogene laherparepvec)
150. Inflectra™ (infliximab-dyyb)
151. Injectable Antipsychotic Medications
152. Intravenous and Subcutaneous Immune Globulin (IVIG)
153. Invega Hafyera™ (paliperidone palmitate)
154. Invega Sustenna™ (paliperidone palmitate extended release)
155. Invega Trinza™ (paliperidone palmitate extended release)
156. Istodax™ (romidepsin)
157. Ixempra™ (ixabepilone)
158. Izervay™ (avacincapted pegol)
159. Jelmyto™ (mitomycin ureteral gel)
160. Jemperli™ (dostarlimab-gxly)
161. Jevtana™ (cabazitaxel)
162. Kadcyla™ (ado-trastuzumab emtansine)
163. Kalbitor™ (ecallantide)
164. Kanuma™ (sebelipase alfa)
165. Keytruda™ (pembrolizumab)
166. Khapzory™ (levoleucovorin)
167. Kimmtrak™ (tebentafusp-tebn)
168. Kimyrsa™ (oritavancin)
169. Kisunla™ (donanemab-azbt)
170. Korsuva™ (difelikefalin)
171. Krystexxa™ (pegloticase)
172. Kymriah™ (tisagenlecleucel)
173. Kyprolis™ (carfilzomib)
174. Lamzede™ (velmanase alfa-tycv)
175. Lantidra™ (donislecel-jujn)

176. Lemtrada™ (alemtuzumab)
177. Lenmeldy™ (atidarsagene autotemcel)
178. Leqembi™ (lecanemab-irmb)
179. Leqvio™ (inclisiran)
180. Leukine™ (sargramostim)
181. Libtayo™ (cemiplimab-rwlc)
182. Loqtorzi™ (toripalimab-tpzi)
183. Lucentis™ (ranibizumab)
184. Lumizyme™ (alglucosidase alfa)
185. Lumoxiti™ (moxetumomab pasudotox-tdfk)
186. Lunsumio™ (mosunetuzumab-axgb)
187. Lutathera™ (lutetium Lu 177 dotatate)
188. Luxturna™ (voretigene-neparvovec-rzyl)
189. Lyfgenia™ (lovotibeglogene autotemcel)
190. Lymphir™ (denileukin diftotox-cxdl)
191. Margenza™ (vincristine sulfate liposome)
192. Medical Benefit Drug Optimization Program
193. Mepsevii™ (vestronidase alfa-vjbk)
194. Mircera™ (epotin beta)
195. Monjuvi™ (tafasitamab-cxix)
196. Monovisc™ (hyaluronan or derivative)
197. Mylotarg™ (gemtuzumab ozogamicin)
198. Myobloc™ (Botulinum toxin Type B)
199. Naglazyme™ (galsulfase)
200. Neulasta™ (pegfilgrastim)/Neulasta OnPro™
201. Neupogen™ (filgrastim)
202. Nexviazyme™ (avalglucosidase alfa-ngpt)
203. Nivestym™ (filgrastim-aafi)
204. Nplate™ (romiplostim)
205. Nucala™ (mepolizumab)
206. Nulibry™ (fosdenopterin)
207. Nulojix™ (belatacept)
208. Nuzyra™ (omadacycline)
209. Nypozi™ (filgrastim-txid)
210. Nyvepria™ (pegfilgrastim-apgf)
211. Ocrevus™ (ocrelizumab)
212. Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq)
213. Octagam™ (intravenous immune globulin)
214. Olinvyk™ (oliceridine)
215. Omisirge™ (omidubicel-onlv)
216. Omvoh IV™ (mirikizumab-mrkz)
217. Onivyde™ (irinotecan liposome)
218. Onpattro™ (patisiran).
219. Opdivo™ (nivolumab)
220. Opdivo Qvantig™ (nivolumab/hyaluronidase-nvhy)

221. Opdualag™ (nivolumab and relatlimab-rmbw)
222. Orencia™ (abatacept)
223. Orthovisc™ (hyaluronate sodium)
224. Otulfi™ (ustekinumab-aaaz)
225. Oxlumo™ (lumasiran)
226. Padcev™ (enfortumab vedotinejfv)
227. palonosetron HCl (Posfrea)
228. Panzyga™ (intravenous immune globulin)
229. Parsabiv™ (etelcalcetide)
230. Pavblu™ (afibercept-ayyh)
231. Pedmark™ (sodium thiosulfate)
232. Perseris™ (risperidone)
233. PiaSky™ (crovalimab-akkz)
234. Pluvicto™ (lutetium Lu 177 vipivotide tetraxetan)
235. Polivy™ (polatuzumab vedotin-piiq)
236. Pombiliti™ (cipaglucosidase alfa-atga)
237. Portrazza™ (necitumumab)
238. Poteligeo™ (mogamulizumab-kpkc)
239. Praxbind™ (idarucizumab)
240. Prevymis IV™ (letermovir)
241. Prialt™ (ziconotide intrathecal infusion)
242. Privigen™ (intravenous immune globulin)
243. Procrit™ (epoetin alfa)
244. Prolastin-C™ (human alpha₁-proteinase inhibitor)
245. Prolia™ (denosumab)
246. Provenge™ (sipuleucel-T)
247. Pyzchiva™ (ustekinumab-ttwe)
248. Qalsody™ (tofersen)
249. Qutenza™ (capsaicin topical system)
250. Quzyttir cetirizine™ (hydrochloride injection)
251. Radicava™ (edaravone)
252. Reblozyl™ (luspatercept-aamt)
253. Rebyota™ (fecal microbiota, live-jslm)
254. Recarbrio™ (imipenem, cilastatin and relabactam)
255. Releuko™ (filgrastim-ayow)
256. Remicade™ (infliximab)
257. Remodulin™ (treprostinil)
258. Renflexis™ (infliximab-abda)
259. Retacrit™ (epoetin alfa-epbx)
260. Revcovi™ (elapegademase-lvlr)
261. Rezzayo™ (rezafungin)
262. Riabni™ (rituximab-arrx)
263. Risperdal Consta™ (risperidone microspheres)
264. Rituxan™ (rituximab)

265. Rituxan Hycela™ (rituximab/hyaluronidase)
266. Roctavian™ (valoctocogene roxaparvovec-rvox)
267. Rolvedon™ (eflapegrastim-xnst)
268. Ruconest™ (C1 esterase inhibitor [recombinant])
269. Ruxience™ (rituximab-pvvr)
270. Rybrevant™ (amivantamab-vmjw)
271. Rykindo™ (risperidone)
272. Rylaze™ (asparaginase erwinia chrysanthemi-rywn)
273. Ryplazim™ (plasminogen, human-tvmh)
274. Rystiggo™ (rozanolixizumab-noli)
275. Rytelo™ (imetelstat)
276. Sandostatin LAR™ (octreotide acetate)
277. Saphnelo™ (anifrolumab-fnia)
278. Sarclisa™ (isatuximab-irfc)
279. Scenesse™ (afamelanotide)
280. Signifor™ LAR (pasireotide)
281. Simponi Aria™ (golimumab)
282. Site of Care Review Guidelines for Infusion Drugs and Specialty Medications
283. Sivextro™ (tedizolid phosphate)
284. Skyrizi™ (risankizumab-rzaa)
285. Skysona™ (elivaldogene autoemcel)
286. Soliris™ (eculizumab)
287. Spevigo™ (spesolimab-sbzo)
288. Spinraza™ (nusinersen)
289. Spravato™ (esketamine)
290. Stelara™ (ustekinumab)
291. Stimufend™ (pegfilgrastim-fpgk)
292. Supprelin™ LA (histrelin acetate implant)
293. Sustol™ (granisetron ER)
294. Susvimo™ (ranibizumab)
295. Syfovre™ (pegcetacoplan)
296. Sylvant™ (siltuximab)
297. Synagis™ (palivizumab)
298. Synojoynt™ (hyaluronan or derivative)
299. Synribo™ (omacetaxine mepesuccinate)
300. Talvey™ (talquetamab-tgvs)
301. Tecartus™ (brexucabtagene autoleucel)
302. Tecelra™ (afamitresgene autoleucel)
303. Tecentriq™ (atezolizumab)
304. Tecentriq Hybreza™ (atezolizumab and hyaluronidase-tqjs)
305. Tecvayli™ (teclistamab-cqyv)
306. Tepadina™ (thiotepa)
307. Tepezza (teprotumumab-trbw)
308. Terlivaz™ (terlipressin)

309. Tevimbra™ (tislelizumab-jsgr)
310. Tezspire™ (tezepelumab-ekko)
311. Tivdak™ (tisotumab vedotin-tftv)
312. Torisel™ (temsirolimus)
313. Trastuzumab™ (Herceptin)
314. Tremfya™ (guselkumab)
315. Triluron™ (hyaluronan or derivative)
316. Triptodur™ (triptorelin)
317. Trisenox™ (arsenic trioxide)
318. TriVisc™ (hyaluronan or derivative)
319. Trodelvy (sacituzumab govitecan-hziy)
320. Truxima™ (rituximab-abbs)
321. Tysabri™ (natalizumab)
322. Tzield™ (teplizumab-mzwv)
323. Udenyca™ (pegfilgrastim-cbqv)
324. Ultomiris™ (ravulizumab-cwvz)
325. Unituxin™ (dinutuximab)
326. Uplinza™ (inebilizumab-cdon)
327. Uzedy™ (risperidone)
328. Vabomere™ (meropenem/vaborbactam)
329. Vabysmo™ (faricimab)
330. Varubi™ IV (rolapitant)
331. Vectibix™ (panitumumab)
332. Velcade™ (bortezomib)
333. Veopoz™ (pozelimab-bbfg)
334. Veletri™ (epoprostenol)
335. Viltepso™ (viltolarsen)
336. Vimizim™ (elosulfase alfa)
337. Visco-3™ (sodium hyaluronate)
338. Viscosupplementation
339. Voraxaze™ (glucarpidase)
340. VPRIV™ (velaglucerase alfa)
341. Vyepi™ (eptinezumab-jjmr)
342. Vyjuvek™ (beremagene geperpavec-svdt)
343. Vyloy™ (zolbetuximab-clzb)
344. Vyondys 53™ (golodirsen)
345. Vyvgart™ (efgartigimod alfa-fcab) and Vyvgart™ Hytrulo
(Efgartigimod Alfa and Hyaluronidase Injection)
346. Vyxeos™ (daunorubicin/cytarabine liposomal)
347. White Blood Cell Stimulating Factors
348. Xacduro™ (sulbactam and durlobactam)
349. Xembify™ (intravenous immune globulin)
350. Xenleta IV™ (lefamulin)
351. Xenpozyme™ (olipudase alfa-rpcp)
352. Xeomin™ (incobotulinumtoxinA)

353. XeravaTM (eravacycline)
354. XgevaTM (denosumab)
355. XiaflexTM (collagenase clostridium histolyticum)
356. XofigoTM (radium RA 223 dichloride)
357. XolairTM (omalizumab)
358. YcanthTM (cantharidin)
359. YervoyTM (Ipilimumab)
360. YescartaTM (axicabtagene ciloleucel)
361. YondelisTM (trabectedin)
362. ZaltrapTM (ziv-aflibercept)
363. ZarxioTM (filgrastim-sndz)
364. ZemairaTM (human alpha₁-proteinase inhibitor)
365. ZemdriTM (plazomicin)
366. ZepzelcaTM (lurbinectedin)
367. ZerbaxaTM (ceftolozane/tazobactam)
368. ZevalinTM (ibritumomab tiuxetan)
369. ZiextenzoTM (pegfilgrastim-bmez)
370. Ziihera® (zanidatamab-hrii)
371. ZilrettaTM (triamcinolone acetonide ER injection)
372. ZinplavaTM (bezlotuxumab)
373. ZolgensmaTM (onasemnogene abeparvovec-xioi)
374. ZulressoTM (brexanolone)
375. ZynlontaTM (loncastuxumab tesirine-lpyl)
376. ZyntegloTM (betibeglogene autotemcel)
377. ZynyzTM (retifanlimab-dlwr)
378. Zyprexa RelprevvTM (olanzapine)

Please note that those items with an asterisk (*) are not covered when performed by a Non-Preferred Provider.

Exhibit 4
Preventive Services



Preventive health coverage just for you

Geisinger
HEALTH PLAN

Preventive care

Everyone wants to stay healthy, happy and living the life they love. That's why we provide the highest standard of preventive care services recommended by the Pennsylvania Department of Health, the Pennsylvania State Board of Pharmacy and federal authorities like the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Preventive Services Task Force, the CDC Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the Food and Drug Administration and others. Visit the immunization schedule sections of this flyer for more information.

Many of the preventive services listed are covered with no member cost-sharing at a participating or preferred doctor. (There may be cost-sharing if a doctor provides additional services that aren't part of the preventive care list.) A written or oral prescription must be provided and presented to a preferred pharmacy or preferred mail-order pharmacy for coverage by the plan of all immunizations and over-the-counter supplements.

From health screenings to vaccination reminders and everything in between, we're here to help make better health easier for everyone.

Well baby and well child exams and immunizations – newborn to age 21

Service	Coverage
Anemia	• 4 months based on risk assessment • 12 months • 15 months to 21 years based on risk assessment
Anxiety screening	• Screening for anxiety in children and adolescents age 8 to 18 years
Autism spectrum disorder screening	• 18 and 24 months
Behavioral/social/emotional screening	• Annually from newborn to 21 years
Blood pressure	• Newborn to 30 months based on risk assessment, then annually ages 3 to 21
Body mass index (BMI)	• 24 months, 30 months, then yearly to 21 years
Congenital hypothyroidism screening	• All newborns • Note: Infants born premature, ill or with very low birth weight may benefit from more than one screening due to decreased sensitivity and specificity of screening
Critical congenital heart defect	• At birth
Depression and suicide risk screening	• Annually 12–21 years
Developmental screening	• 9, 18 and 30 months
Developmental surveillance	• Newborn, 3–5 days • 1–6 months; 12, 15, 24 months; annually 3–21 years
Dyslipidemia (cholesterol/lipid disorders)	• 24 months based on risk assessment • Years 4, 6, 8, 9–11, 12, 13, 14, 15, 16, 17–21 years based on risk assessment
Fluoride supplementation	• 6, 9, 12, 18, 24, 30 months; then annually age 3–16 years based on risk assessment
Fluoride varnish	• 6 months to 5 years
Hearing screening <i>Note: Not complete hearing examination</i>	• Newborn, 3–5 days to 2 months, 4 months to 3 years based on risk assessment, annually 4–6 years, 8 years, 10 years, between 11 and 14 years, between 15 and 17 years, and between 18 and 21 years • Other years based on risk assessment

Well baby and well child exams and immunizations – newborn to age 21 (continued)

Service	Coverage
High body mass index (BMI) in children and adolescents: interventions	Clinicians are recommended to provide or refer children and adolescents 6 years or older with a high BMI (≥ 95th percentile for age and sex) to comprehensive, intensive behavioral interventions
History, length/height, weight, head circumference and physical exam	- Newborn to 24 months - Additional visit at 2–4 days for infants discharged less than 48 hours after delivery
HIV	11, 12, 13, 14 years based on risk assessment - Once between 15–18 years - Ages 19–21 based on risk assessment
Immunizations <i>Note: Immunizations necessary for international travel are not covered</i>	- Refer to Attachment A below – <i>CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger</i> - Questions about immunization coverage? Call the number on the back of your member ID card.
Lead	6, 9, 12, 18, 24 months based on risk assessment - Years 3–6 based on risk assessment
Maternal depression screening	1, 2, 4 and 6 months at well-child visits
Metabolic/hemoglobinopathies	- According to state law - All newborns
Newborn bilirubin	At birth
Newborn blood draw	- At birth, 3–5 days - Additional blood draws based on risk assessment
Oral health	6 and 9 months 12, 18, 24, 30 months and annually 3–6 years based on risk assessment
PKU screening	At birth
Prophylactic ocular (eye) medication to prevent blindness secondary to gonococcal ophthalmia neonatorum	All newborns
Sexually transmitted infections	Annually 11–21 years, based on risk assessment

Well baby and well child exams and immunizations – newborn to age 21 (continued)

Service	Coverage
Sickle cell disease screening	• All newborns
Tobacco, alcohol or drug use assessment	• 11–21 years based on risk assessment
Tobacco use in children and adolescents: primary care interventions	• Interventions, including education or brief counseling, to prevent initiation of tobacco use among school-age children and adolescents who have not started to use tobacco
Tuberculosis	• Months 1, 6, 12, 24 and yearly from age 3 based on risk assessment as indicated by history and/or symptoms
Vision screening <i>Note: Not complete eye examination</i>	• Newborn to 30 months based on risk assessment, annually 3–6 years, then every other year until and including age 15 (or annually based on risk assessment) • At least once in all children 3 to 5 years to detect amblyopia or its risk factors

Young adult and adult health screenings and interventions

Service	Coverage
Abdominal aortic aneurysm; one-time screening	- Men 65–75 years who have ever smoked - Limited to one per lifetime
Anxiety screening	Screening for anxiety in all adults, including pregnant or postpartum persons
Blood pressure (hypertension) screening	In adults 18 years and older with office blood pressure measurement
BRCA-related cancer: Risk assessment, genetic counseling and genetic testing	- Genetic counseling for adults who have family history of ovarian or breast cancer - If indicated after genetic counseling, a genetic laboratory test of the BRCA1 and BRCA2 genes for people assessed to be at an increased risk, based on a clinical risk assessment tool, of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer (PA Act 1 of 2023)
Cervical dysplasia	21 years
Cholesterol/lipid disorders and statin use	Use of a statin for the prevention of CVD for adults 40–75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater
Colorectal cancer screening <i>Note: Single source brand-name drugs (brand-name drugs without a generic equivalent) and generic drugs are covered with no cost-sharing for members 45 to 75 years.</i>	- The following tests for all adults 45–75 years - High-sensitivity fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) annually or sDNA-FIT every 1 to 3 years - Flexible sigmoidoscopy every 5 years - Colonoscopy every 10 years - CT colonography every 5 years
Depression and suicide risk screening in adults	Screening for depression in the general adult population, including pregnant and postpartum people, as well as older adults
Diabetes screening: prediabetes and Type 2 diabetes	- Asymptomatic adults 35–70 years who are overweight or obese - Includes HbA1c screening, LDL-C screening and nephropathy screening
Fall prevention in older adults	Exercise interventions for community-dwelling adults 65 years or older who are at increased risk for falls
Hepatitis B screening	Adolescents and adults at increased risk of infection
Hepatitis C virus (HCV) infection screening	Adults 18–79 years
HIV infection prevention: Preexposure prophylaxis (PrEP) <i>Note: This includes baseline and monitoring services associated with dispensing PrEP.</i>	Clinicians are recommended to prescribe preexposure prophylaxis (PrEP) using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV

Young adult and adult health screenings and interventions (continued)

Service	Coverage
HIV screening	- Adolescents and adults 15–65 years - Younger adolescents and older adults at increased risk of infection
Immunizations <i>Note: Immunizations necessary for international travel are not covered</i>	- Refer to Attachment B below – <i>CDC Recommended Adult Immunization Schedule for ages 19 and older</i> - Questions about immunization coverage? Call the number on the back of your member ID card.
Lung cancer screening – Low-dose computed tomography	Annual screening with low-dose computed tomography (LDCT) in adults 50–80 years who have a 20-pack-per-year smoking history, currently smoke or have quit smoking in the past 15 years
Nutrition counseling	Offer or refer adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity
Prevention of herpes zoster (shingles)	Vaccination of people 50 years old and older
Sexually transmitted infection (STI) counseling	All sexually active adolescents and adults who are at increased risk for sexually transmitted infections (STIs)
Skin cancer behavioral counseling	Counseling all young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons 6 months to 24 years with fair skin types to reduce their risk of skin cancer
Sudden cardiac arrest/death	17–21 years based on risk assessment
Syphilis infection: screening	All persons who are at increased risk for infection
Tobacco use/cessation interventions	Clinicians are recommended to ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)—approved pharmacotherapy for cessation to nonpregnant adults who use tobacco
Tuberculin test	Screening for latent tuberculosis infections in populations at increased risk
Unhealthy alcohol use in adolescents and adults: screening and behavioral counseling interventions	Screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant people, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use
Unhealthy drug use screening	Screening by asking questions about unhealthy drug use in adults 18 years and older
Weight loss to prevent obesity-related morbidity and mortality in adults: Behavioral interventions	Offering or referring adults with body mass index (BMI) of 30 or higher (calculated in weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions

Women's health screenings and interventions

Service	Coverage
Bacteriuria screening	Screening for asymptomatic bacteriuria using urine culture in pregnant persons
BRCA-related cancer: risk assessment, genetic counseling and genetic testing	- Women with a personal or family history of breast, ovarian, tubal or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool - Genetic counseling for people who have family history of ovarian or breast cancer - If indicated after genetic counseling, a genetic laboratory test of the BRCA1 and BRCA2 genes for those assessed to be at an increased risk, based on a clinical risk assessment tool, of potentially harmful mutations in the BRCA1 or BRCA2 genes due to a personal or family history of breast or ovarian cancer (PA Act 1 of 2023)
Breast cancer screening (mammogram) for average-risk women	- Biennial screening mammography for women 40–74 years - Average-risk women should initiate mammography screening no earlier than age 40 and no later than age 50 - Screening mammography should occur at least biennially and as frequently as annually - Women may require additional imaging to complete the screening process to address findings on the initial screening mammography. If additional imaging (e.g., MRI, ultrasound, mammography) and pathology evaluation are indicated, these services are also recommended to complete the screening process for malignancies. - Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening - Benefits of mammography screening are payable only if performed by a mammography-service doctor who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992
Breast cancer preventive medication	Women at risk for breast cancer and at low risk for adverse medication effects
Breast cancer screening for women believed to be at increased risk of breast cancer/extremely dense breast tissue (supplemental annual screening)	Annual supplemental magnetic resonance imaging (MRI) or ultrasound for women at increased risk of breast cancer/extremely dense breast tissue (BI-RADS level 3 and 4) if recommended by the treating physician (PA Act 1 of 2023)
Breastfeeding promotion	Interventions or referrals, during pregnancy and after birth, to support breastfeeding

Women's health screenings and interventions (continued)

Service	Coverage
Breastfeeding services and supplies	• Comprehensive lactation support services (including consultation and counseling, education by clinicians and peer support services (mental health and substance use peer support excluded) and breastfeeding equipment and supplies) by a trained doctor during the antenatal, perinatal, pregnancy and/or in the postpartum periods to optimize the successful initiation and maintenance of breastfeeding • Breastfeeding equipment and supplies include but are not limited to double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies; access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump • Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services • The costs for renting breastfeeding equipment are covered
Cervical cancer and hrHPV: screening	• Every 3 years in women 21–65 years, if not combined with high-risk human papillomavirus (hrHPV) testing • For women 30–65 years, cervical cytology every 5 years if combined with hrHPV testing
Chlamydia screening	• All sexually active females 24 years and younger • Adult women 25 years and older who are at risk
Diabetes screening after pregnancy	• Women with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with Type 2 diabetes mellitus should be screened for diabetes mellitus
Intimate partner and domestic violence screening and counseling	• Screening adolescents and adult women for intimate partner and domestic violence at least annually, and, when needed, providing or referring for initial intervention services • Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect and the threat of violence, abuse or both • Intervention services include, but are not limited to, counseling, education, harm reduction strategies and appropriate supportive services
Female contraceptive methods and counseling	• All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered as prescribed by the member's participating doctor or OB/GYN; contraceptive care includes screening, education, counseling and provision of contraceptives (including in the immediate postpartum period)

Women's health screenings and interventions (continued)

Service	Coverage
Folic acid supplementation	All persons planning to or who could become pregnant take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid
Gonorrhea screening	- All sexually active females 24 years and younger - Adult women 25 years and older who are at risk
Healthy weight and weight gain in pregnancy	Offering pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy
Hepatitis B screening	Pregnant persons at their first prenatal visit
HIV screening	- All pregnant persons, including those who present in labor or at delivery whose HIV status is unknown - A screening test for HIV for all adolescent and adult women, age 15 and older, at least once during their lifetime; earlier or additional screening should be based on risk; rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection - Risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk
Obesity prevention in midlife women	Counseling midlife women 40–60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m²) to maintain weight or limit weight gain to prevent obesity
Osteoporosis screening	- Women 65 years and older - Postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis, as estimated by clinical risk assessment
Patient navigation services for breast and cervical cancer screening	Patient navigation services for breast and cervical cancer screening and follow-up, as relevant
Perinatal depression	Clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions
Preeclampsia prevention: aspirin	Low-dose (81 mg/d) for pregnant people, after 12 weeks gestation, who are at high risk
Rh incompatibility test – Rh (D) blood typing and antibody testing	- Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care - Repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.

Women's health screenings and interventions (continued)

Service	Coverage
Screening for diabetes in pregnancy	- Pregnant persons at 24 weeks of pregnancy of gestation or after - Women with risk factors for Type 2 diabetes or gestational diabetes mellitus (GDM) should be screened for preexisting diabetes before 24 weeks of gestation — ideally at the first prenatal visit, based on current clinical best practices
Screening for hypertensive disorders of pregnancy	Screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy
Sexually transmitted infections (STIs), counseling	Directed behavioral counseling for sexually active adolescent and adult women at an increased risk for STIs; for adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment
Syphilis screening	Early, universal screening for syphilis infection during pregnancy; if a person is not screened early in pregnancy, screening at the first available opportunity
Tobacco use/cessation interventions	Clinicians are recommended to ask all pregnant persons about tobacco use, advise them to stop using tobacco and provide behavioral interventions for cessation to pregnant persons who use tobacco
Urinary incontinence screening	Screening women for urinary incontinence annually
Well-woman preventive visits	- At least one preventive care visit per year beginning in adolescence and continuing across the lifespan - These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status and risk factors - Well-woman visits also include prepregnancy, prenatal, postpartum and interpregnancy visits

Many of these preventive services are covered with no member cost sharing when obtained from a participating/preferred doctor, unless otherwise noted. If your doctor provides medical services during your preventive care visit that are not included in the preventive care list, these items will be considered under your standard medical plan coverage. This means you may be responsible for cost sharing. See your plan materials for specific details about your plan coverage.

This document is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the benefit documents and applicable riders under which a member is enrolled. This managed care plan may not cover all your healthcare expenses. Read your Subscription Certificate and riders carefully to determine which healthcare services are covered.

These preventive health services are based on recommendations from the Pennsylvania Department of Health, the Pennsylvania State Board of Pharmacy, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Food and Drug Administration and the Health Resources and Services (HRSA) supported Women's Preventive Services Guidelines. The guidelines are subject to change by these organizations.

Geisinger Health Plan may refer collectively to healthcare coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated healthcare delivery and coverage organization.

2659029 9/2025

Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (Geisinger Health Plan) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity and sex stereotypes). Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Geisinger Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, call Geisinger Health Plan at 800-447-4000 or TTY: 711.

If you believe that Geisinger Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 N. Academy Ave., Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
ghpcivilrights@thehealthplan.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the civil rights grievance coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-447-4000 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-447-4000 (TTY: 711) o hable con su proveedor.

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-447-4000 (TTY: 711) 或與您的提供者討論。

אכטונג: אויב איר רעדט אידיש, זענען דא אומזיסטע שפראך הילף סערוויסעס וואס קענען צוגעשטעלט ווערן פאר אייך. נויטיגע צוגאבליכע הילף און סערוויסעס כדי צו צושטעלן אינפארמאציע אין א צוגענגליכע פארמאטן ווערן אויך צוגעשטעלט פריי פון אפצאל. רופט 1-800-447-4000 (TTY: 711) אדער רעדט צו אייער פראוויידער.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-447-4000 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) (1-800-447-4000) أو تحدث إلى مقدم الخدمة

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-447-4000 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-447-4000 (Người khuyết tật: 1-711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-447-4000 (TTY: 711) ou parlez à votre fournisseur.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-447-4000 (tty: 711) o parla con il tuo fornitore.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-447-4000 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-447-4000 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-447-4000 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-447-4000 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

AKIYESI: Ti o ba so Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-800-447-4000 (TTY: 711) tabi sọrọ si olupese rẹ.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական օգնությունների անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Չանգահարեք 1-800-447-4000 հեռախոսահամարով (TTY` 711) կամ խոսեք Ձեր մատակարարի հետ:

ATTACHMENT A - Recommended Child and Adolescent Immunization Schedule

UNITED STATES
2025

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	RSV-mAb	Beyfortus
Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA	Comirnaty/Pfizer-BioNTech COVID-19 Vaccine
		Spikevax/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
Dengue vaccine	DEN4CYD	Dengvaxia
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
<i>Haemophilus influenzae</i> type b vaccine	Hib (PRP-T)	ActHIB Hiberix
	Hib (PRP-OMP)	PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated: egg-based)	IIV3	Multiple
Influenza vaccine (inactivated: cell-culture)	cclIV3	Flucelvax
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Mpox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15	Vaxneuvance
	PCV20	Prevnar 20
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo
Rotavirus vaccine	RV1	Rotarix
	RV5	RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac Tdvax
Varicella vaccine	VAR	Varivax
Combination vaccines (use combination vaccines instead of separate injections when appropriate)		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus, and <i>Haemophilus influenzae</i> type b vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix
		Quadacel
DTaP, inactivated poliovirus, <i>Haemophilus influenzae</i> type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child and adolescent immunization schedule

- 1** Determine recommended vaccine by age (**Table 1**)
- 2** Determine recommended interval for catch-up vaccination (**Table 2**)
- 3** Assess need for additional recommended vaccines by medical condition or other indication (**Table 3**)
- 4** Review vaccine types, frequencies, intervals, and considerations for special situations (**Notes**)
- 5** Review contraindications and precautions for vaccine types (**Appendix**)
- 6** Review new or updated ACIP guidance (**Addendum**)

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/acip/index.html) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.



Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- General Best Practice Guidelines for Immunization (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/



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CS310020-E

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs		
Respiratory syncytial virus (RSV-mAb [Nirsevimab])	1 dose depending on maternal RSV vaccination status (See Notes)					1 dose (8 through 19 months), See Notes													
Hepatitis B (HepB)	1st dose	←----- 2nd dose -----→			←----- 3rd dose -----→														
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes														
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			←----- 4th dose -----→				5th dose							
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes			← 3rd or 4th dose (See Notes) →											
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose			←----- 4th dose -----→											
Inactivated poliovirus (IPV)			1st dose	2nd dose	←----- 3rd dose -----→							4th dose					See Notes		
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					1 or more doses of 2024–2025 vaccine (See Notes)														
Influenza (IIV3, ccIIV3)					1 or 2 doses annually									1 dose annually					
Influenza (LAIV3)											1 or 2 doses annually		1 dose annually						
Measles, mumps, rubella (MMR)					See Notes		←----- 1st dose -----→				2nd dose								
Varicella (VAR)							←----- 1st dose -----→				2nd dose								
Hepatitis A (HepA)					See Notes		2-dose series (See Notes)												
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose					
Human papillomavirus (HPV)															See Notes				
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes													1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes					
Respiratory syncytial virus vaccine (RSV [Abrysvo])														Seasonal administration during pregnancy (See Notes)					
Dengue (DEN4CYD: 9–16 yrs)													Seropositive in endemic dengue areas (See Notes)						
Mpox																			

Table 2

Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B	Birth	4 weeks	8 weeks <i>and</i> at least 16 weeks after first dose minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	4 weeks	4 weeks maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	4 weeks	4 weeks	6 months	6 months A fifth dose is not necessary if the fourth dose was administered at age 4 years or older <i>and</i> at least 6 months after dose 3
<i>Haemophilus influenzae</i> type b	6 weeks	No further doses needed if first dose was administered at age 15 months or older. 4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months.	No further doses needed if previous dose was administered at age 15 months or older 4 weeks if current age is younger than 12 months <i>and</i> first dose was administered at younger than age 7 months <i>and</i> at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown 8 weeks <i>and</i> age 12 through 59 months (as final dose) if current age is younger than 12 months <i>and</i> first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months <i>and</i> first dose was administered before the 1st birthday <i>and</i> second dose was administered at younger than 15 months; OR if both doses were PedvaxHIB and were administered before the 1st birthday	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	No further doses needed for healthy children if first dose was administered at age 24 months or older 4 weeks if first dose was administered before the 1st birthday 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after	No further doses needed for healthy children if previous dose was administered at age 24 months or older 4 weeks if current age is younger than 12 months <i>and</i> previous dose was administered at <7 months old 8 weeks (as final dose for healthy children) if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older <i>and</i> at least 1 dose was administered before age 12 months	8 weeks (as final dose) This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	4 weeks	4 weeks if current age is <4 years 6 months (as final dose) if current age is 4 years or older	6 months (minimum age 4 years for final dose)	
Measles, mumps, rubella	12 months	4 weeks			
Varicella	12 months	3 months			
Hepatitis A	12 months	6 months			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	8 weeks	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	8 weeks			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	6 months if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	Routine dosing intervals are recommended.			
Hepatitis A	N/A	6 months			
Hepatitis B	N/A	4 weeks	8 weeks <i>and</i> at least 16 weeks after first dose		
Inactivated poliovirus	N/A	4 weeks	6 months A fourth dose is not necessary if the third dose was administered at age 4 years or older <i>and</i> at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years OR if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	4 weeks			
Varicella	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older			
Dengue	9 years	6 months	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count ^a		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm ³	≥15% and ≥200/mm ³						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID ^b								
DTaP/Tdap	DTaP									
	Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes								
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years ^c			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

Page 4

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2025.

Additional information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥ 4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤ 4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥ 5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination

(minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vaccine])

Routine vaccination

Age 6 months–4 years

All vaccine doses should be from the same manufacturer.

- Unvaccinated:**
 - 2 doses 2024–25 Moderna at 0, 4–8 weeks
 - 3 doses 2024–25 Pfizer-BioNTech at 0, 3–8, and at least 8 weeks after dose 2
- Incomplete initial vaccination series before 2024–25 vaccine with:**
 - 1 dose Moderna:** complete initial series with 1 dose 2024–25 Moderna 4–8 weeks after most recent dose
 - 1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech 8 weeks apart (administer dose 1 3–8 weeks after most recent dose).
 - 2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.
- Completed initial vaccination series before 2024–25 vaccine with:**
 - 2 or more doses Moderna:** 1 dose 2024–25 Moderna at least 8 weeks after the most recent dose.
 - 3 or more doses Pfizer-BioNTech:** 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 5–11 years

- Unvaccinated:** 1 dose 2024–25 Moderna or Pfizer-BioNTech
- Previously vaccinated before 2024–25 vaccine with 1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Age 12–18 years

- Unvaccinated:**
 - 1 dose 2024–25 Moderna or Pfizer-BioNTech
 - 2 doses 2024–25 Novavax at 0, 3–8 weeks
- Previously vaccinated before 2024–25 vaccine with:**
 - 1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
 - 1 dose Novavax:** 1 dose 2024–25 Novavax 3–8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.
 - 2 or more doses Novavax:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.

Special situation

Persons who are moderately or severely immunocompromised.

Age 6 months–4 years

Use vaccine from the same manufacturer for all doses (**initial vaccination series and additional doses**).

- Unvaccinated:**
 - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna 6 months later [minimum interval 2 months]). May administer additional doses.*
 - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 8 weeks after dose 2, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- Incomplete initial 3-dose vaccination series before 2024–25 vaccine:**
 - Previous vaccination with Moderna**
 - 1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*
 - 2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna 6 months later (minimum interval 2 months). May administer additional doses of Moderna.*
 - Previous vaccination with Pfizer-BioNTech**
 - 1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 8 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*
 - 2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 8 weeks after most recent dose, followed by 1 dose 2024–25 Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Pfizer-BioNTech.*

COVID-19 vaccination - continued

Completed initial 3-dose vaccination series before 2024–25 vaccine with:

- **3 or more doses Moderna:** 2 doses 2024–25 Moderna 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna.*
- **3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Pfizer-BioNTech.*

Age 5–11 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

Unvaccinated:

- 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*

Incomplete initial 3-dose vaccination series before 2024–25 vaccine:

Previous vaccination with Moderna

- **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
- **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*

Previous vaccination with Pfizer-BioNTech

- **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*
- **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Pfizer-BioNTech.*

Completed initial 3-dose vaccination series before 2024–25 vaccine with:

- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Pfizer-BioNTech.*

Age 12–18 years

Use vaccine from the same manufacturer for all doses in the initial vaccination series.

Unvaccinated:

- 4 doses (**3-dose initial series Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- 4 doses (**3-dose initial series Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- 3 doses (**2-dose initial series Novavax** at 0, 3 weeks, followed by 1 dose Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Incomplete initial vaccination series before 2024–25 vaccine:

Previous vaccination with Moderna

- **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Previous vaccination with Pfizer-BioNTech

- **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Previous vaccination with Novavax

- **1 dose Novavax:** complete initial series with 1 dose 2024–25 Novavax at least 3 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

Notes Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

COVID-19 vaccination - continued

Completed initial 3-dose vaccination series before 2024–25 vaccine with:

- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*
- **2 or more doses Novavax:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses of Moderna or Novavax or Pfizer-BioNTech.*

***Additional doses of 2024–25 COVID-19 vaccine for moderately or severely immunocompromised:** based on shared clinical decision-making and administered at least 2 months after the most recent dose (see Table 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#table-02). For description of moderate and severe immunocompromising conditions and treatment, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromising-conditions-treatment.

Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose.

For information about transition from age 4 years to age 5 years or age 11 years to age 12 years during COVID-19 vaccination series, see Tables 1 and 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html.

For information about interchangeability of COVID-19 vaccines, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#Interchangeability.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
 - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by booster doses at ages 15–18 months and 4–6 years)
 - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
 - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Children younger than age 7 years with a contraindication specific to the pertussis component of DTaP:** May administer Td for all recommended remaining doses in place of DTaP. Encephalopathy within 7 days of vaccination when not attributable to another identifiable cause is the only contraindication specific to the pertussis component of DTaP. For additional information, see www.cdc.gov/pertussis/hcp/vaccine-recommendations/td-offlabel.html.
- **Wound management in children younger than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine:** For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, Pentacel, or Vaxelis:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
 - *Vaxelis is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)
- **American Indian and Alaska Native infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Catch-up vaccination not required.

For other catch-up guidance, see Table 2. Vaxelis can be used for catch-up vaccination in children younger than age 5 years. Follow the catch-up schedule even if Vaxelis is used for one or more doses. For detailed information on use of Vaxelis see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Haemophilus influenzae type b vaccination

- continued

Special situations

• Chemotherapy or radiation treatment:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.

• Hematopoietic stem cell transplant (HSCT):

- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

• Anatomic or functional asplenia (including sickle cell disease):

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5 years or older

- 1 dose

• Elective splenectomy:

Unvaccinated* persons age 15 months or older

- 1 dose (preferably at least 14 days before procedure)

• HIV infection:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5–18 years

- 1 dose

• Immunoglobulin deficiency, early component complement deficiency, or early component complement inhibitor use:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated = Less than routine series (through age 14 months) **or** no doses (age 15 months or older)

Hepatitis A vaccination

(minimum age: 12 months for routine vaccination)

Routine vaccination

- **2-dose series** (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

- **Unvaccinated persons through age 18 years should complete a 2-dose series** (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive HepA-HepB (Twinrix) as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
 - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses (separated by at least 6 months) between age 12–23 months.
 - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

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Hepatitis B vaccination

(minimum age: birth)

Routine vaccination

• Mother is HBsAg-negative

- 3-dose series at age 0, 1–2, 6–18 months (**use monovalent HepB vaccine for doses administered before age 6 weeks**)
 - Birth weight $\geq 2,000$ grams: 1 dose within 24 hours of birth if medically stable
 - Birth weight $< 2,000$ grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still $< 2,000$ grams)
- Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum intervals (see Table 2):** when 4 doses are administered, substitute “dose 4” for “dose 3” in these calculations.
- **Final (3rd or 4th) dose:** age 6–18 months (**minimum age 24 weeks**)

• Mother is HBsAg-positive

- **Birth dose (monovalent HepB vaccine only):** administer HepB vaccine and hepatitis B immune globulin (HBIG) in separate limbs within 12 hours of birth, regardless of birth weight.
- **Birth weight < 2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
- **Final (3rd or 4th) dose:** administer at age 6 months (**minimum age 24 weeks**).
- Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Hepatitis B vaccination - continued

• **Mother is HBsAg-unknown**

If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive.

- **Birth dose (monovalent HepB vaccine only):**

• Birth weight $\geq 2,000$ grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.

• Birth weight $< 2,000$ grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses).

- **Final (3rd or 4th) dose:** administer at age 6 months (**minimum age 24 weeks**).

- If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years may receive:
 - **Heplisav-B**: 2-dose series at least 4 weeks apart
 - **PreHevbrio***: 3-dose series at 0, 1, and 6 months
 - **HepA-HepB (Twinrix)**: 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

- Revaccination is generally not recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs < 10 mIU/mL) is recommended for certain populations, including:
 - Infants born to HBsAg-positive mothers
 - Persons who are predialysis or on maintenance dialysis
 - Other immunocompromised persons
 - For detailed revaccination recommendations, see www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant women.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated.
- 2- or 3-dose series depending on age at initial vaccination:
 - **Age 9–14 years at initial vaccination:** 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
 - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series **of any valency** has been completed using recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination

(minimum age: 6 months [IIV3], 2 years [LAIV3], 18 years [recombinant influenza vaccine, RIV3])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
 - **Age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2024, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
 - **Age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2024: 1 dose.
 - **Age 9 years or older:** 1 dose
 - **Age 18 years solid organ transplant recipients receiving immunosuppressive medications:** high-dose inactivated (HD-IIV3) and adjuvanted inactivated (aIIV3) influenza vaccines are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

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Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV* may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV* may be used if parents or caregivers express a preference.

Catch-up vaccination

- **Unvaccinated children and adolescents:** 2-dose series at least 4 weeks apart*
- The maximum age for use of MMRV* is 12 years.

Special situations

• International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.*

• Children age 12 months or older:

- Unvaccinated: 2-dose series (separated by at least 4 weeks*) before departure
- Previously received 1 dose: administer dose 2 at least 4 weeks after dose 1*

- In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** If MMRV is used, the minimum interval between MMRV doses is 3 months.

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Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi], 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination

- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

- **Age 13–15 years:** 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- **Age 16–18 years:** 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

• Menveo*

- Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
- Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
- Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

• MenQuadfi

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel to countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/):

• Children younger than age 24 months:

- Menveo* (age 2–23 months)

- Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
- Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
- Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)

- **Children age 2 years or older:** 1 dose Menveo* or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits: 1 dose Menveo* or MenQuadfi

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- **Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease** (e.g., those with complement component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.

- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.*

Note: For MenACWY **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see “Meningococcal serogroup B vaccination” section below for more information).

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Meningococcal serogroup B vaccination

(minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba; MenACWY-TT/MenB-FHbp, Penbraya])

Shared clinical decision-making

• **Adolescents not at increased risk age 16–23 years (preferred age 16–18 years)* based on shared clinical decision-making.**

- **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use.

- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

For MenB **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Children age 10 years or older may receive a dose of Penbraya (MenACWY-TT/MenB-FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Mpox vaccination

(minimum age: 18 years [Jynneos])

Special situations

- **Age 18 years and at risk for mpox infection:** complete 2-dose series, 28 days apart.

Risk factors for mpox infection include:

- Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
 - A new diagnosis of at least 1 sexually transmitted disease
 - More than 1 sex partner
 - Sex at a commercial sex venue
 - Sex in association with a large public event in a geographic area where mpox transmission is occurring
- Persons who are sexual partners of the persons described above
- Persons who anticipate experiencing any of the situations described above

- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.

For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html

Pneumococcal vaccination

(minimum age: 6 weeks [PCV15], [PCV 20]; 2 years [PPSV23])

Routine vaccination with PCV

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

- Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Special situations

Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years

- Any incomplete* PCV series with:
 - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
 - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23.
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

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Pneumococcal vaccination - continued

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

- Any incomplete* PCV series:
 - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
 - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: wcms-wp.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
 - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
 - Doses of OPV administered on or after April 1, 2016, should not be counted.
 - For guidance to assess doses documented as “OPV,” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Respiratory syncytial virus immunization (minimum age: birth [Nirsevimab, RSV-mAb, Beyfortus])

Routine immunization

• Infants born October – March in most of the continental United States*

- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

• Infants born April–September in most of the continental United States*

- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

• Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:

- 1 dose nirsevimab shortly before start of second RSV season*

• Ages 8–19 months who are American Indian or Alaska Native: 1 dose nirsevimab shortly before start of second RSV season*

• Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:

1 additional dose of nirsevimab after surgery. See www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf

***Note:** While the timing of the onset and duration of RSV season may vary, administration of nirsevimab is recommended October through March in most of the continental United States (optimally October through November or within 1 week of birth). Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

Respiratory syncytial virus vaccination (RSV [Abrysvo])

Routine vaccination

• Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:

1 dose Abrysvo. Administer RSV vaccine regardless of previous RSV infection.

- Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.

• All other pregnant women: RSV vaccine not recommended

• Subsequent pregnancies:

additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

• Rotarix:

2-dose series at age 2 and 4 months

• RotaTeq:

3-dose series at age 2, 4, and 6 months

- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

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Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Age 11–12 years:** 1 dose Tdap (adolescent booster)
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36

Note: Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)
- **Age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
 - **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years
 - **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years
- **DTaP inadvertently administered on or after age 7 years:**
 - **Age 7–9 years:** DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.
 - **Age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster dose.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
 - For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.
- *Fully vaccinated* = 5 valid doses of DTaP or 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination
(minimum age: 12 months)

Routine vaccination

- 2-dose series at age 12–15 months, 4–6 years
 - VAR or MMRV may be administered*
 - Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4 weeks may be counted as valid).
- *Note:** For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
 - **Age 7–12 years:** Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
 - **Age 13 years and older:** Routine interval: 4–8 weeks (minimum interval: 4 weeks)
 - The maximum age for use of *MMRV* is 12 years.

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Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: [Contraindication and Precautions, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season](#) | [MMWR \(cdc.gov\)](#), and [Contraindications and Precautions for COVID-19 Vaccination](#)

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
COVID-19 mRNA vaccines [Pfizer-BioNTech, Moderna]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine³	- Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID-19 vaccine³; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID-19 vaccine - Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine - Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) - Moderate or severe acute illness, with or without fever
COVID-19 protein subunit vaccine [Novavax]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Novavax COVID-19 vaccine³	- Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Novavax COVID-19 vaccine³; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Novavax COVID-19 vaccine - Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine - Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) - Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	- Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, cclIV, RIV, or LAIV of any valency) - Severe allergic reaction (e.g., anaphylaxis) to any vaccine component⁴ (excluding egg)	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable (ccIIV3) [Flucelvax]	Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component⁴ of ccIIV3	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. - Moderate or severe acute illness with or without fever
Influenza, recombinant injectable (RIV3) [Flublok]	Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component⁴ of RIV3	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. - Moderate or severe acute illness with or without fever
Influenza, live attenuated (LAIV3) [Flumist]	- Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) - Severe allergic reaction (e.g., anaphylaxis) to any vaccine component⁴ (excluding egg) - Children age 2–4 years with a history of asthma or wheezing - Anatomic or functional asplenia - Immunocompromised due to any cause including, but not limited to, medications and HIV infection - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment - Pregnancy - Cochlear implant - Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak - Children and adolescents receiving aspirin or salicylate-containing medications - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Asthma in persons age 5 years old or older - Persons with underlying medical conditions other than those listed under contraindications that might predispose to complications after wild-type influenza virus infection, e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus) - Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should **NOT** be administered. Kroger A, Bahta L, Hunter P. [ACIP General Best Practice Guidelines for Immunization](#).

2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. [ACIP General Best Practice Guidelines for Immunization](#).

3. See [package inserts](#) and [FDA EUA fact sheets](#) for a full list of vaccine ingredients. mRNA COVID-19 vaccines contain polyethylene glycol (PEG).

4. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See [Package inserts for U.S.-licensed vaccines](#).

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
Dengue (DEN4CYD)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) - Lack of laboratory confirmation of a previous dengue infection	- Pregnancy - HIV infection without evidence of severe immunosuppression - Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	- Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid-containing vaccine - History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine - For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized - Moderate or severe acute illness with or without fever
<i>Haemophilus influenzae</i> type b (Hib)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Younger than age 6 weeks	Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin	Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including yeast - Pregnancy: PreHevBrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated⁴	Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB) [Twinrix]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin and yeast	Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Pregnancy: HPV vaccination not recommended.	Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR) Measles, mumps, rubella, and varicella (MMRV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) - Pregnancy - Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent - For MMRV only: HIV infection of any severity	- Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) - History of thrombocytopenia or thrombocytopenic purpura - Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing - Moderate or severe acute illness with or without fever - For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology - If using MMRV, see Varicella/MMRV for additional precautions
Meningococcal ACWY (MenACWY) MenACWY-CRM [Menveo] MenACWY-TT [MenQuadfi]	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - For Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid—or CRM197—containing vaccine - For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	- For MenACWY-CRM only: Preterm birth if younger than age 9 months - Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB-4C [Bexsero] MenB-FHbp [Trumenba]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	- Pregnancy - For MenB-4C only: Latex sensitivity - Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe allergic reaction to a tetanus toxoid-containing vaccine	Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid-containing vaccine or its component³	Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	- Pregnancy - Moderate or severe acute illness with or without fever
RSV monoclonal antibody (RSV-mAb)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Rotavirus (RV) RV1 [Rotarix] RV5 [RotaTeq]	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe combined immunodeficiency (SCID) - History of intussusception	- Altered immunocompetence other than SCID - Chronic gastrointestinal disease - RV1 only: Spina bifida or bladder exstrophy - Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid-containing vaccine - History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine - For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized - Moderate or severe acute illness with or without fever
Varicella (VAR) Measles, mumps, rubella, and varicella (MMRV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) - Pregnancy - Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent - For MMRV only: HIV infection of any severity	- Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) - Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) - Use of aspirin or aspirin-containing products - Moderate or severe acute illness with or without fever - If using MMRV, see MMR/MMRV for additional precautions

- When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
- When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
- Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
- For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevBrio while pregnant, please visit www.prehevbrio.com/safety.
- Full prescribing information for BEYFORTUS (nirsevimab-alip) www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf.

Addendum

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines	Recommendations	Effective Date of Recommendation*
No new vaccines or vaccine recommendations to report		

ATTACHMENT B - Recommended Adult Immunization Schedule

UNITED STATES
2025

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA	Comirnaty/Pfizer-BioNTech COVID-19 Vaccine Spikevax/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB, Hiberix, PedvaxHIB
Hepatitis A vaccine	HepA	Havrix, Vaqta
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix
Hepatitis B vaccine	HepB	Engerix-B, Heplisav-B, PreHevbrio, Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated, egg-based)	IIV3	Multiple
	aIIV3	Fluad
	HD-IIV3	Fluzone High-Dose
Influenza vaccine (inactivated, cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (recombinant)	RIV3	Flublok
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II, Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Mpox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15	Vaxneuvance
	PCV20	Prevnar 20
	PCV21	Capvaxive
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo, Arexvy, mResvia
Tetanus and diphtheria vaccine	Td	Tenivac
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel, Boostrix
Varicella vaccine	VAR	Varivax
Zoster vaccine, recombinant	RZV	Shingrix

*Administer recommended vaccines if vaccination history is incomplete or unknown.
Do not restart or add doses to vaccine series if there are extended intervals between doses.
The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the adult immunization schedule

- 1** Determine recommended vaccinations by age (**Table 1**)
- 2** Assess need for additional recommended vaccinations by medical condition or other indication (**Table 2**)
- 3** Review vaccine types, dosing frequencies and intervals, and considerations for special situations (**Notes**)
- 4** Review contraindications and precautions for vaccine types (**Appendix**)
- 5** Review new or updated ACIP guidance (**Addendum**)

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), American Pharmacists Association (www.pharmacist.com), and Society for Healthcare Epidemiology of America (www.shea-online.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.



Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html.

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/index.html



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Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2025

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID–19	1 or more doses of 2024–2025 vaccine (See Notes)			2 or more doses of 2024–2025 vaccine (See Notes)
Influenza inactivated (IIV3, ccIIV3) Influenza recombinant (RIV3)	1 dose annually			1 dose annually (HD–IIV3, RIV3, or allIV3 preferred)
Influenza inactivated (aIIV3; HD–IIV3) Influenza recombinant (RIV3)	Solid organ transplant (See Notes)			
Influenza live, attenuated (LAIV3)	1 dose annually			
Respiratory syncytial virus (RSV)	Seasonal administration during pregnancy (See Notes)		60 through 74 years (See Notes)	≥75 years
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (See Notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			For health care personnel (See Notes)
Varicella (VAR)	2 doses (if born in 1980 or later)	2 doses		
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (See Notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PCV21, PPSV23)			See Notes	
				See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication (See Notes for booster recommendations)			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication (See Notes for booster recommendations)			
	19 through 23 years			
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication			
Mpox	2 doses			
Inactivated poliovirus (IPV)	Complete 3-dose series if incompletely vaccinated. Self-report of previous doses acceptable (See Notes)			

 Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of immunity
 Recommended vaccination for adults with an additional risk factor or another indication
 Recommended vaccination based on shared clinical decision-making
 No Guidance/ Not Applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition or Other Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions or indications are often not mutually exclusive. If multiple medical conditions or indications are present, refer to guidance in all relevant columns. See Notes for medical conditions or indications not listed.

VACCINE	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count		Men who have sex with men	Asplenia, complement deficiency	Heart or lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease; alcoholism ^a	Diabetes	Health care Personnel ^b
			<15% or <200/mm ³	≥15% and ≥200/mm ³							
COVID–19		See Notes									
Influenza inactivated Influenza recombinant		Solid organ transplant (See Notes)	1 dose annually								
LAIV3					1 dose annually if age 19–49 years		1 dose annually if age 19–49 years				
RSV	Seasonal administration (See Notes)	See Notes				See Notes			Liver disease (See Notes)	See Notes	
Tdap or Td	Tdap: 1 dose each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	*										
VAR	*			See Notes							
RZV		See Notes									
HPV	*	3-dose series if indicated									
Pneumococcal											
HepA											
Hep B	See Notes									Age ≥ 60 years	
MenACWY											
MenB											
Hib		HSCT: 3 doses ^c				Asplenia: 1 dose					
Mpox	See Notes				See Notes						See Notes
IPV		Complete 3-dose series if incompletely vaccinated. Self-report of previous doses acceptable (See Notes)									

Recommended for all adults who lack documentation of vaccination, OR lack evidence of immunity
Not recommended for all adults, but recommended for some adults based on either age OR increased risk for or severe outcomes from disease
Recommended vaccination based on shared clinical decision-making
Recommended for all adults, and additional doses may be necessary based on medical condition or other indications. See Notes.
Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction
Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated
No Guidance/ Not Applicable

a. Precaution for LAIV3 does not apply to alcoholism.

b. See Notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations.

c. Hematopoietic stem cell transplant.

For vaccination recommendations for persons ages 18 years or younger, see the Recommended Child and Adolescent Immunization Schedule, 2025: www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html

Additional Information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥ 4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤ 4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥ 5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3–2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8–1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the adult immunization schedule except PPSV23, RSV, RZV, Mpox, and COVID–19 vaccines are covered by the National Vaccine Injury Compensation Program (VICP). Mpox and COVID–19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID–19 vaccination

Routine vaccination

Age 19–64 years

- **Unvaccinated:**
 - 1 dose 2024–25 Moderna or Pfizer-BioNTech
 - 2 doses 2024–25 Novavax at 0, 3–8 weeks
- **Previously vaccinated before 2024–25 vaccine with:**
 - **1 or more doses Moderna or Pfizer-BioNTech:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
 - **1 dose Novavax:** 1 dose 2024–25 Novavax 3–8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.
 - **2 or more doses Novavax:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose.
 - **1 or more doses Janssen:** 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech.

Age 65 years and older

- **Unvaccinated:** follow recommendations above for unvaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).
- **Previously vaccinated before 2024–25 vaccine:** follow recommendations above for previously vaccinated persons ages 19–64 years **and** administer dose 2 of 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months).

Special situations

Persons who are moderately or severely immunocompromised. Use vaccine from the same manufacturer for all doses in the initial vaccination series.

- **Unvaccinated:**
 - 4 doses (**3-dose initial series 2024–25 Moderna** at 0, 4 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
 - 4 doses (**3-dose initial series 2024–25 Pfizer-BioNTech** at 0, 3 weeks, and at least 4 weeks after dose 2, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
 - 3 doses (**2-dose initial series 2024–25 Novavax** at 0, 3 weeks, followed by 1 dose Moderna or Novavax or Pfizer-BioNTech 6 months later [minimum interval 2 months]). May administer additional doses.*
- **Incomplete initial vaccination series before 2024–25 vaccine:**
 - **Previous vaccination with Moderna**
 - **1 dose Moderna:** complete initial series with 2 doses 2024–25 Moderna at least 4 weeks apart (administer dose 1 4 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*
 - **2 doses Moderna:** complete initial series with 1 dose 2024–25 Moderna at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

COVID-19 vaccination - continued

- Previous vaccination with Pfizer-BioNTech

• **1 dose Pfizer-BioNTech:** complete initial series with 2 doses 2024–25 Pfizer-BioNTech at least 4 weeks apart (administer dose 1 3 weeks after most recent dose), followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

• **2 doses Pfizer-BioNTech:** complete initial series with 1 dose 2024–25 Pfizer-BioNTech at least 4 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

- Previous vaccination with Novavax

• **1 dose Novavax:** complete initial series with 1 dose 2024–25 Novavax at least 3 weeks after most recent dose, followed by 1 dose 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). May administer additional doses.*

• Completed the initial vaccination series before 2024–25 vaccine with:

- **3 or more doses Moderna or 3 or more doses Pfizer-BioNTech:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses.*

- **2 or more doses Novavax:** 2 doses 2024–25 Moderna or Novavax or Pfizer-BioNTech 6 months apart (minimum interval 2 months). Administer dose 1 at least 8 weeks after the most recent dose. May administer additional doses.*

***Additional doses of 2024–25 COVID-19 vaccine for moderately or severely immunocompromised:** based on shared clinical decision-making and administered at least 2 months after the most recent dose (see Table 2 at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#table-02). For description of moderate and severe immunocompromising conditions and treatment, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromising-conditions-treatment.

Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose.

For information about interchangeability of COVID-19 vaccines, see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#Interchangeability.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Haemophilus influenzae type b vaccination

Special situations

• **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib vaccine

- **Elective splenectomy:** 1 dose preferably at least 14 days before splenectomy

• **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

• **Any person who is not fully vaccinated and requests vaccination** (identification of risk factor not required): complete 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA–HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 5 months])

Special situations

• **Any person who is not fully vaccinated and who is at risk for hepatitis A virus infection or severe disease from hepatitis A virus infection:** complete 2-dose series HepA or 3-dose series HepA–HepB as above. Risk factors include:

- **Chronic liver disease** including persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal.

- **HIV infection**

- **Men who have sex with men**

- **Injection or noninjection drug use**

- **Persons experiencing homelessness**

- **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection

- **Travel in countries with high or intermediate endemic hepatitis A:** HepA–HepB (Twinrix) may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months.

- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A: dose 1 as soon as adoption is planned; preferably at least 2 weeks before adoptee's arrival.

Hepatitis A vaccination - *continued*

- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure**, including health care setting serving persons who use injection or noninjection drugs, or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

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Hepatitis B vaccination

Routine vaccination

- **Age 19 through 59 years:** complete a 2- or 3- or 4-dose series
 - 2-dose series only applies when 2 doses of Heplisav-B are used at least 4 weeks apart
 - 3-dose series Engerix-B, PreHevbrio*, or Recombivax HB at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 8 weeks; dose 1 to dose 3 = 16 weeks)
 - 3-dose series HepA-HepB (Twinrix) at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 5 months)
 - 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant women.

- **Age 60 years or older without** known risk factors for hepatitis B virus infection **may** receive a HepB vaccine series.
- **Age 60 years or older with** known risk factors for hepatitis B virus infection **should** receive a HepB vaccine series.
- **Any adult age 60 years of age or older** who requests HepB vaccination **should** receive a HepB vaccine series.
 - **Risk factors for hepatitis B virus infection include:**
 - **Chronic liver disease** including persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal.
 - **HIV infection**
 - **Sexual exposure risk** e.g., sex partners of hepatitis B surface antigen (HBsAg)-positive persons, sexually active persons not in mutually monogamous relationships, persons seeking evaluation or treatment for a sexually transmitted infection, men who have sex with men

- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** e.g., household contacts of HBsAg-positive persons, residents and staff of facilities for developmentally disabled persons, health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids, persons on maintenance dialysis (including in-center or home hemodialysis and peritoneal dialysis), persons who are predialysis, and patients with diabetes**
- **Incarceration**
- **Travel in countries with high or intermediate endemic hepatitis B**

****Age 60 years or older with diabetes:** Based on shared clinical decision making, 2-, 3-, or 4-dose series as above.

Special situations

- **Patients on dialysis:** complete a 3- or 4-dose series
 - 3-dose series Recombivax HB at 0, 1, 6 months (Note: Use Dialysis Formulation 1 mL = 40 mcg)
 - 4-dose series Engerix-B at 0, 1, 2, and 6 months (Note: Use 2 mL dose instead of the normal adult dose of 1 mL)
- **Age 20 years or older with an immunocompromising condition:** complete a 2- or 3- or 4-dose series.
 - 3-dose series Recombivax HB at 0, 1, 6 months (Note: Use Dialysis Formulation 1 mL = 40 mcg)
 - 4-dose series Engerix-B at 0, 1, 2, and 6 months (Note: Use 2 mL dose instead of the normal adult dose of 1 mL)
 - 2-doses series Heplisav-B at 0, 1 months
 - 3-dose series PreHevbrio* at 0, 1, 6 months

Human papillomavirus vaccination

Routine vaccination

- **All persons through age 26 years:** complete 2- or 3-dose series depending on age at initial vaccination or condition.
- **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
- **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series of any valency has been completed using the recommended dosing intervals.

Shared clinical decision-making

- **Adults age 27–45 years:** Based on shared clinical decision-making, complete a 2-dose series (if initiated age 9–14 years) or 3-dose series (if initiated ≥ 15 years).

For additional information on shared clinical decision-making for HPV; see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-hpv-shared-clinical-decision-making-hpv.pdf

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**
- **Immunocompromising conditions, including HIV infection:** complete 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **Pregnancy:** Pregnancy testing is not needed before vaccination. HPV vaccination is not recommended until after pregnancy. No intervention needed if inadvertently vaccinated while pregnant.

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- **Solid organ transplant recipients aged 19 through 64 years receiving immunosuppressive medications:** HD-IIV3 and aIIV3 are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- **Age 65 years or older:** Any one of HD-IIV3, RIV3, or aIIV3 is preferred. If none of these three vaccines is available, then any other age-appropriate influenza vaccine should be used.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., caregivers, healthcare workers) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

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Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
- **Evidence of immunity:** Born before 1957 (except for health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility): 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 percentages $\geq 15\%$ and CD4 count ≥ 200 cells/mm³ for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 percentage $< 15\%$ or CD4 count < 200 cells/mm³
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **In mumps outbreak settings,** for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

Measles, mumps, and rubella vaccination*- continued*• **Health care personnel:**

- **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for protection against measles or mumps or 1 dose for protection against rubella.
- **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart for protection against measles or mumps or at least 1 dose for protection against rubella.

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Meningococcal vaccination**Special situations for MenACWY**

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose primary series Menveo or MenQuadfi at least 8 weeks apart; 1 booster dose 5 years after primary series and every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or for microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose Menveo or MenQuadfi; 1 booster dose 5 years after primary series and every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:** 1 dose Menveo or MenQuadfi

For MenACWY recommendations **in outbreak setting** (e.g., in community or organizational settings, or among men who have sex with men) and **additional meningococcal vaccination** information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred)* not at increased risk for meningococcal disease:** based on shared clinical decision-making
- **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, or microbiologists routinely exposed to *Neisseria meningitidis*.**
 - **Bexsero or Trumenba (use same brand for all doses including booster doses):** 3-dose primary series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3).
 - **Booster doses:** 1 booster dose one year after primary series and every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy due to lack of safety data in pregnant women. May administer if at increased risk and vaccination benefits outweigh potential risks.

For MenB recommendations **in outbreak setting** (e.g., in community or organizational settings, or among men who have sex with men) and **additional meningococcal vaccination** information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Adults may receive a single dose of Penbraya (MenACWY–TT/MenB–FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For adults not at increased risk, if Penbraya is used for dose 1 MenB, then MenB–FHbp (Trumenba) should be administered for dose 2 MenB. For adults at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Mpox vaccination

Special situations

- **Any person at risk for mpox infection:** complete 2-dose series, 28 days apart.
 - **Risk factors for mpox infection include:**
 - Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
 - A new diagnosis of at least 1 sexually transmitted disease
 - More than 1 sex partner
 - Sex at a commercial sex venue
 - Sex in association with a large public event in a geographic area where mpox transmission is occurring
 - Persons who are sexual partners of the persons described above
 - Persons who anticipate experiencing any of the situations described above
 - **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.
 - **Health care personnel:** Vaccination to protect against occupational risk in healthcare settings is not routinely recommended.
- For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html.

Pneumococcal vaccination

Routine vaccination

- **Age 50 years or older who have:**
 - **Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
 - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
 - **Previously received only PCV7:** follow the recommendation above.
 - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
 - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
 - If PCV15 is used, no additional PPSV23 doses are recommended.
 - **Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older:** 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.
 - **Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older:** Based on shared clinical decision-making, 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose.

Special situations

- **Age 19–49 years with certain underlying medical conditions or other risk factors** who have:**
 - **Not previously received a PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
 - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
 - **Previously received only PCV7:** follow the recommendation above.
 - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
 - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
 - If PCV15 is used, no additional PPSV23 doses are recommended.
 - **Previously received PCV13 and 1 dose of PPSV23:**
 - Cochlear implant, cerebrospinal fluid leak, or an immunocompromising condition*: 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.
 - Alcoholism, chronic heart/liver/lung disease, cigarette smoking, or diabetes mellitus: no additional PCV or PPSV23 doses recommended at this time. Review pneumococcal recommendations when age 50 years or older.

Adults aged 19 years and older who have received PCV20 or PCV21: no additional pneumococcal vaccine dose recommended.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm.

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Pneumococcal vaccination - *continued*

PPSV23 not available: adults aged 19 years or older who received PCV15 but have not yet completed PPSV23 series, can complete the series with either 1 dose of PCV20 or 1 dose of PCV21 if they no longer have access to PPSV23.

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html.

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiencies, iatrogenic immunosuppression, generalized malignancy, HIV infection, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplant, congenital or acquired asplenia, or sickle cell disease or other hemoglobinopathies.

****Note:** Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV infection, Hodgkin disease, immunodeficiencies, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplant, or sickle cell disease or other hemoglobinopathies.

Poliovirus vaccination**Routine vaccination**

- **Adults known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most adults who were born and raised in the United States can assume they were vaccinated against polio as children.

Special situations

- **Adults at increased risk for exposure to poliovirus who completed primary series*:** may administer one lifetime IPV booster.

***Note:** Complete primary series consists of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

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Respiratory syncytial virus vaccination**Routine vaccination**

- **Pregnant women of any age:**

- **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:**

1 dose **Abrysvo**. Administer RSV vaccine regardless of previous RSV infection.

- Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.

- **All other pregnant women:** RSV vaccine not recommended

- **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities on timing of administration. Refer to the 2025 Child and Adolescent Immunization Schedule for considerations regarding nirsevimab administration to infants.

Age 75 years or older

- **Unvaccinated:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended
- **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

Respiratory syncytial virus vaccination - *continued*

Special situations

• Age 60–74 years:

- **Unvaccinated and at increased risk of severe RSV disease**:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended.
- **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

Persons 60 years and older can get RSV vaccine at any time but it is best to administer in late summer and early fall before RSV spreads in communities—ideally August through October in most of continental United States. For further guidance, see www.cdc.gov/mmwr/volumes/73/wr/mm7332e1.htm.

****Note: People can self-attest to the presence of a risk factor. The following medical and other conditions increase the risk of severe RSV disease:**

- Chronic cardiovascular disease e.g., heart failure, coronary artery disease, congenital heart disease. Excludes isolated hypertension.
- Chronic lung or respiratory disease e.g., chronic obstructive pulmonary disease, emphysema, asthma, interstitial lung disease, cystic fibrosis
- End stage renal disease or dependence on hemodialysis or other renal replacement therapy
- Diabetes mellitus complicated by chronic kidney disease, neuropathy, retinopathy, or other end-organ damage
- Diabetes mellitus requiring treatment with insulin or sodium–glucose cotransporter 2 (SGLT2) inhibitor
- Neurologic or neuromuscular conditions causing impaired airway clearance or respiratory muscle weakness e.g., post–stroke dysphagia, amyotrophic lateral sclerosis, muscular dystrophy. Excludes history of stroke without impaired airway clearance.
- Chronic liver disease e.g., cirrhosis

- Chronic hematologic conditions e.g., sickle cell disease, thalassemia
- Severe obesity (body mass index ≥ 40 kg/m²)
- Moderate or severe immune compromise
- Residence in a nursing home
- Other chronic medical conditions or risk factors that a health care provider determines would increase the risk of severe disease due to viral respiratory infection e.g., frailty, concern for presence of undiagnosed chronic medical conditions, residence in a remote or rural community where escalation of medical care is challenging.

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Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Completed primary series and received at least 1 dose Tdap at age 10 years or older:** Td or Tdap every 10 years thereafter
- **Completed primary series and did NOT receive Tdap at age 10 years or older:** 1 dose Tdap, then Td or Tdap every 10 years thereafter
- **Unvaccinated or incomplete primary vaccination series for tetanus, diphtheria, or pertussis:** administer remaining doses (1, 2, or 3 doses) to complete 3-dose primary series. 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks later, and a third dose of Td or Tdap 6–12 months later (Tdap is preferred as first dose and can be substituted for any Td dose), then Td or Tdap every 10 years thereafter.

Special situations

- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus–toxoid–containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus–toxoid–containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus–toxoid–containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus–toxoid–containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

Varicella vaccination**Routine vaccination**

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles–mumps–rubella–varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose.
- **Evidence of immunity:** U.S.–born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease.

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.–born before 1980.
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.–born before 1980.
- **HIV infection with CD4 percentages $\geq 15\%$ and CD4 count ≥ 200 cells/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage $< 15\%$ or CD4 count < 200 cells/mm³.
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination**Routine vaccination**

- **Age 50 years or older*:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination.

***Note:** Serologic evidence of prior varicella is not necessary for zoster vaccination. However, if serologic evidence of varicella susceptibility becomes available, providers should follow ACIP guidelines for varicella vaccination first. RZV is not indicated for the prevention of varicella, and there are limited data on the use of RZV in persons without a history of varicella or varicella vaccination.

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
 - **Immunocompromising conditions (including persons with HIV regardless of CD4 count)**:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). For detailed information, see www.cdc.gov/shingles/hcp/vaccine-considerations/immunocompromised-adults.html
- **Note:** If there is no documented history of varicella, varicella vaccination, or herpes zoster, providers should refer to the clinical considerations for use of RZV in immunocompromised adults aged ≥ 19 years and the ACIP varicella vaccine recommendations for further guidance: www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm

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Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4–1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season | [MMWR \(cdc.gov\)](https://www.cdc.gov/mmwr), and Contraindications and Precautions for COVID–19 Vaccination

Vaccines and Other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
COVID–19 mRNA vaccines [Pfizer–BioNTech, Moderna]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID–19 vaccine³	- Diagnosed non–severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID–19 vaccine³; or non–severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID–19 vaccine - Myocarditis or pericarditis within 3 weeks after a dose of any COVID–19 vaccine - Multisystem inflammatory syndrome in children (MIS–C) or multisystem inflammatory syndrome in adults (MIS–A) - Moderate or severe acute illness, with or without fever
COVID–19 protein subunit vaccine [Novavax]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Novavax COVID–19 vaccine³	- Diagnosed non–severe allergy (e.g., urticaria beyond the injection site) to a component of Novavax COVID–19 vaccine³; or non–severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Novavax COVID–19 vaccine - Myocarditis or pericarditis within 3 weeks after a dose of any COVID–19 vaccine - Multisystem inflammatory syndrome in children (MIS–C) or multisystem inflammatory syndrome in adults (MIS–A) - Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	- Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, cclIV, RIV, or LAIV of any valency) - Severe allergic reaction (e.g., anaphylaxis) to any vaccine component⁴ (excluding egg)	- Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Moderate or severe acute illness with or without fever
Influenza, cell culture–based inactivated injectable (ccIV3) [Flucelvax]	Severe allergic reaction (e.g., anaphylaxis) to any ccIV of any valency, or to any component⁴ of ccIV3	- Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. - Moderate or severe acute illness with or without fever
Influenza, recombinant injectable (RIV3) [Flublok]	Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component⁴ of RIV3	- Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIV, or LAIV of any valency. If using RIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. - Moderate or severe acute illness with or without fever
Influenza, live attenuated (LAIV3) [Flumist]	- Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIV, RIV, or LAIV of any valency) - Severe allergic reaction (e.g., anaphylaxis) to any vaccine component⁴ (excluding egg) - Anatomic or functional asplenia - Immunocompromised due to any cause including, but not limited to, medications and HIV infection - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment - Pregnancy - Cochlear implant - Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	- Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine - Asthma in persons aged 5 years or older - Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] - Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. [ACIP General Best Practice Guidelines for Immunization](#).

2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. [ACIP General Best Practice Guidelines for Immunization](#).

3. See [package inserts](#) and [FDA EUA fact sheets](#) for a full list of vaccine ingredients. mRNA COVID–19 vaccines contain polyethylene glycol (PEG).

4. Vaccination providers should check FDA–approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See [Package inserts for U.S.–licensed vaccines](#).

Vaccine	Contraindicated or Not Recommended ¹	Precautions ²
<i>Haemophilus influenzae</i> type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including yeast • Pregnancy: PreHevbrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated ⁴	• Moderate or severe acute illness with or without fever
Hepatitis A–Hepatitis B vaccine (HepA–HepB) [Twinrix]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Pregnancy: HPV vaccination not recommended	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-γ release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) (MenACWY–CRM) [Menveo] (MenACWY–TT) [MenQuadfi]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • For MenACWY–CRM only: severe allergic reaction to any diphtheria toxoid- or CRM197-containing vaccine • For MenACWY–TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB–4C [Bexsero] MenB–FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Pregnancy • For MenB–4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY–TT/MenB–FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV15, PCV20, PCV21)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria–toxoid-containing vaccine or to its vaccine component ³	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Pregnancy • Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) to a vaccine component	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus–toxoid-containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria–toxoid containing or tetanus–toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus–toxoid-containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever • Current episode of herpes zoster

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

4. For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevbrio while pregnant, please visit www.prehevbrio.com/#safety.

Addendum

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines	Recommendations	Effective Date of Recommendation*
No new vaccines or vaccine recommendations to report		

*The effective date is the date when the CDC director adopted the recommendation and when the ACIP recommendation became official.