Geisinger Gold

MEDICARE SUPPLEMENT

PLAN F

Geisinger Indemnity Insurance Company
(Called "the Plan")
A Pennsylvania corporation located at
100 North Academy Avenue
Danville, PA 17822-3220

Guaranteed renewable/premium subject to change

This Policy is guaranteed renewable subject to the right of the Plan to terminate, cancel, non-renew or void coverage in accordance with Section 4 of this Policy, and may be renewed by payment of the applicable premium. Subject to the approval of the Pennsylvania Insurance Department, the Plan may adjust the premium rates paid by all Policyholders covered under this Policy. In addition, the premium rate will change based on the current attained age of the Policyholder. For additional information, refer to Section 4 of this Policy.

Policyholder's right to examine Policy for thirty (30) days

Upon initial enrollment, the Policyholder has the right to return this Policy within thirty (30) days of its delivery and to have the premium rate refunded if, after examination of the Policy, the Policyholder is not satisfied for any reason. (See Return of Policy by the Policyholder on page 3.)

This Policy may be returned to:
Geisinger Indemnity Insurance Company
100 North Academy Avenue
Danville, Pennsylvania 17822

Notice to the buyer: this Policy may not Cover all of your medical expenses.

This Policy supersedes and replaces all Medicare Supplement Agreements previously entered into between the Plan and the Policyholder covered under this Policy.

This Policy is non-participating in any divisible surplus of premium.

Geisinger
Gold

MEDICARE SUPPLEMENT

PLAN F

Geisinger Indemnity Insurance Company
100 North Academy Avenue
Danville, Pennsylvania 17822

Thank you for choosing Geisinger Gold Medicare Supplement Plan F.

Geisinger Indemnity Insurance Company is a corporation located in Danville, Pennsylvania that offers this Geisinger Gold Medicare Supplement Plan F. This Policy sets forth the Covered Benefits provided by the Plan. These health care benefits supplement Medicare coverage, in part, by providing coverage for the following:

- The Medicare Coinsurance amount of Part A Medicare Eligible Expense for hospitalization to the extent not covered by Medicare from day sixty-one (61) through day ninety (90) in a Medicare Benefit Period.
- The Medicare Coinsurance amount of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day.
- An additional lifetime benefit maximum of three hundred sixty-five (365) inpatient days of care in a Hospital after the Policyholder has used all of the Medicare allowed days.
- Coverage under Medicare Parts A and B for the first three (3) pints of blood, or the equivalent amount of packed red blood cells (as defined under Federal regulations) during a Medicare Benefit Period.
- The Medicare Coinsurance or Medicare Copayment amount of Part B Medicare Eligible Expenses, subject to the Medicare Part B deductible.
- The cost sharing amount of Part A Medicare Eligible Expenses for hospice care and respite care.
- The Medicare Deductible for Part A.
- Skilled Nursing Facility care Part A Coinsurance.
- The Medicare Deductible for Part B.
- Medicare Part B excess charges.
- Medically Necessary Emergency Care in a foreign country.

The coverage provided to you is defined by the following documents:

1. The Policy, which identifies the terms and conditions of coverage awarded to the Policyholders.
2. Any amendments to the Policy, which inform Policyholders of any changes to the Plan's Covered Benefits or to the terms and conditions of coverage;
3. The Application which is the Policyholder's written request for coverage under the Policy;

4. The Policyholder's Enrollment Letter; and
5. The Policyholder's Identification Card.

In consideration for and upon payment of the appropriate premium, the persons covered under the Policy are entitled to the Covered Benefits set forth herein in accordance with the terms and conditions of this Policy.

Guaranteed Renewable/Premium Subject to Change. This Policy is guaranteed renewable subject to the right of the Plan to terminate, cancel, non-renew or void coverage in accordance with Section 4, and may be renewed by payment of the applicable premium. The premium rate can be raised only if the Plan raises the premium rate for all Policies like yours in the same classification and geographic rating area of the Commonwealth of Pennsylvania. Until the Policyholder is age 99, the premium rate will change each year based on the Policyholder's attained age. This premium rate change will be made on January 1st of each year the Policy remains in effect. Otherwise, your premium rate cannot change unless the Plan makes the same premium rate change for all Policies like yours in the classification and geographic rating area of the Commonwealth of Pennsylvania. Such classification and geographic rating area changes will be effective subject to the approval of the Pennsylvania Insurance Department. Schedules of rates may vary depending upon your Effective Date. For additional information regarding premium rates, refer to Section 4 of this Policy.

The initial premium will be charged based upon the attained age of the Policyholder as of January 1st of the year the application for coverage is approved. Once the Policyholder is accepted and has paid the initial premium, future premiums will be based on the attained age of the Policyholder as of January 1st of the year of renewal, and the classification, gender and rating area as of the initial effective date. All annual Policy renewal premiums will be based on the attained age as of January 1st of the year of renewal. A Policyholder's classification, gender and rating area will remain the same as long as the Policy remains in effect except as set forth in Policy Section 4.1.5 (b).

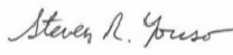
The Policy is guaranteed renewable and shall renew monthly upon payment of the required premium within the Grace Period. Subject to the right of the Plan to terminate coverage, this Policy will remain in effect continually until terminated by the Policyholder or the Plan in accordance with Section 4.2 of this Policy.

Return of Policy within the Thirty (30) day Period. If the Policyholder elects to return this Policy within thirty (30) days of its delivery, the Policyholder may be entitled to a refund. If benefits are paid for claims incurred by the Policyholder during this thirty (30) day period, there shall be no right to a full refund of premium rates paid by the Policyholder. Notwithstanding the foregoing, the Plan shall not be liable for payment of any benefits under this Policy in such refund cases.

For help and information: Policyholders should call the Customer Service Team at **1-800-498-9731** or **TTY: 711** weekdays between 8 a.m. and 6 p.m. in regard to information regarding the Plan, or write to the Plan at: Geisinger Gold Customer Service Team, 100 North Academy Avenue, Danville, PA 17822-3229. The Customer Service Team telephone number indicated above is also listed on the back of the Policyholder's Identification Card.

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

IN WITNESS WHEREOF,
Geisinger Indemnity Insurance Company
has duly executed this Policy



Steven R. Youso
President, Chief Executive Officer
Geisinger Indemnity Insurance Company
100 North Academy Avenue
Danville, PA 17822-3220

John B. Bulger, DO, MBA
Chief Medical Officer
Geisinger Indemnity Insurance Company
100 North Academy Avenue
Danville, PA 17822-3220

Discrimination is against the law

Geisinger Indemnity Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Geisinger Indemnity Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Indemnity Insurance Company:

- Provides free aids and services to people with disabilities 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 these services, call Geisinger Indemnity Insurance Company at 800-447-4000 or TTY: 711.

If you believe that Geisinger Indemnity Insurance Company 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 North Academy Avenue, 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 Avenue 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.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم:711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

HPM 50 alb: Nondiscrimination dev. 9.12.16
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SECTION 1. DEFINITIONS

1. **GENERAL DEFINITIONS**. The following terms, when used in this Policy and all applicable amendments will have the meanings assigned to them below unless these terms are otherwise defined in such other applicable documents (please note that the defined terms will be capitalized when used in document text):

1.1 **Application** means the written request for Coverage under this Policy on a form furnished by the Plan.

1.2 **Assignment** means an agreement between the Provider and the Medicare beneficiary. When the Provider accepts Assignment, such Medicare Provider agrees to accept the Medicare Reasonable Charge set by Medicare as payment in full.

1.3 **Coverage** means coverage under this Policy except as specifically set forth otherwise in this Policy.

1.4 **Covered Benefits or Core Benefits** means a service or supply specified in this Policy for which benefits will be provided pursuant to the terms of the Policy.

1.5 **Creditable Coverage** means the length of time an enrollee had previous continuous health coverage which was not interrupted by a sixty-three (63) day break in coverage. For purposes of this Policy, the term Creditable Coverage does not mean creditable prescription drug coverage, as that term is defined under Medicare.

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

1.7 **Effective Date** means the date the Policyholder's Coverage begins under this Policy as shown on the Enrollment Letter.

1.8 **Emergency Care** means Hospital, physician, and medical care needed immediately because of an injury or an illness of sudden and unexpected onset.

1.9 **Enrollment Letter**. The Enrollment Letter is a letter sent by the Plan to the Policyholder as notification that they have been enrolled in a Geisinger Gold Medicare Supplement Plan. The Enrollment Letter sets forth the Policyholder's Effective Date and monthly premium amount.

1.10 **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 Medicare Part B, 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.

1.11 **Hospital** means an institution which meets the Medicare requirements for a Hospital and participates in the Medicare program.

1.12 **Identification Card** means the card issued by the Plan to a Policyholder pursuant to this Policy which is for identification purposes only. Possession of an Identification Card confers no right to Covered Benefits or other benefits under this Policy. To be entitled to Covered Benefits the holder of the card must, in fact, be a Policyholder on whose behalf all applicable premiums and charges under this Policy have actually been paid.

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

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

b) provided for the diagnosis and the direct care and treatment of the Policyholder'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 Policyholder, or the Policyholder's Health Care Provider; and

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

1.14 **Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

a) **Medicare Part A** means the Hospital Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.
b) **Medicare Part B** means the Supplementary Medical Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.
c) **Medicare Part D** means the Voluntary Prescription Drug Benefit Program provided by the United States Government under Public Law 108-173, Title XVIII of the Social Security Act as amended from time to time.

1.15 **Medicare Benefit Period** or **Benefit Period** means:

a) **For purposes of Medicare Part A expenses**, the period that begins on the first day that the Policyholder receives services as an inpatient in a Hospital and ends after the Policyholder has been discharged from the Hospital and has not received skilled care in any other facility for a period of sixty (60) consecutive days.

b) **For purposes of Medicare Part B expenses**, the calendar year beginning January 1 and ending on December 31.

1.16 **Medicare Coinsurance or Medicare Copayment** means that portion of Medicare Eligible Expenses, or Medicare Reasonable Charges which the Policyholder has the responsibility to pay under Medicare, that are over and above the Medicare Deductible.

1.17 **Medicare Deductible** means the amount which must be paid by the Policyholder during each Medicare Benefit Period before payment of benefits under Medicare Part A and/or Part B begins.

* Note: Certain benefits have a separate Medicare Deductible such as Hospital benefits, medical/surgical benefits, and blood.

1.18 **Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

1.19 **Medicare Non-Participating Provider** means a Health Care Provider licensed to provide services or supplies under Medicare Part B but who does not have a Medicare participation agreement in

place, and may or may not elect to accept Assignment on each Medicare claim that is filed. A Medicare Non-Participating Provider who does not accept Assignment will not accept the Medicare Reasonable Charge for a certain service or supply as payment in full, and may charge his/her patient more than the Medicare Reasonable Charge, unless otherwise prohibited by law.

1.20 **Medicare Opt-Out Provider** means a Health Care Provider eligible to provide services or supplies under Medicare Part B but who has "opted out" of Medicare such that he or she foregoes any payments from Medicare, to his or her patients or themselves, and enters into private contracts with Medicare beneficiaries to provide eligible services, and bills Medicare beneficiaries directly for services provided.

1.21 **Medicare Reasonable Charge** means the amount approved by Medicare for services and supplies.

1.22 **PACE** means the Program of All-Inclusive Care for the Elderly, the federal Medicare program permanently established by the United States Government under the Balanced Budget Act of 1997, Public Law 101-33 which provides comprehensive, community-based care and services to individuals otherwise in need of a nursing home level of care.

* Note: The term PACE used in this Policy does not include income-based prescription drug assistance programs offered and administered by states for the benefit of their age 65 or older qualified residents. Such programs provide individuals with greater access to prescription drug medications.

1.23 **Plan** means Geisinger Indemnity Insurance Company or its designated agent.

1.24 **Policy** means this Policy, including the Application and amendments, if any, between the Plan and the Policyholder, the Enrollment Letter, the Identification Card and any supplemental applications submitted by the Policyholder and approved by the Plan. The Policy describes the Covered Benefits and the terms and conditions of coverage.

1.25 **Policyholder** means a Medicare beneficiary, enrolled in Medicare Part A and Part B who has been enrolled by the Plan under this Policy.

1.26 **Skilled Nursing Facility** means an institution which meets the Medicare requirements for a Skilled Nursing Facility and participates in the Medicare program.

1.27 **United States** shall mean all the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, Northern Mariana Islands and for purposes of Covered Services rendered on board ship, the territorial waters adjoining the land areas of the United States, subject to those limitations imposed by Medicare.

SECTION 2. COVERED BENEFITS

Covered Benefits under this Policy are available for Medicare Eligible Expenses, except as otherwise excluded or limited in this Policy. In addition, certain benefits which are not covered by Medicare are available under this Policy only when they are determined to be Medically Necessary. The benefits for Medicare Deductible(s), Medicare Coinsurance and Medicare Copayment under this Policy will be revised automatically to be consistent with cost sharing changes under Medicare. The Covered Benefits provided under this Policy are personal to the Policyholder and may not be transferred to another person. Please refer to your Outline of Coverage for illustrative tables detailing the Covered Benefits set forth below which are available for this Policy.

IDENTIFICATION OF COVERED BASIC BENEFITS

2. Subject to all terms, conditions, definitions, exclusions and limitations in this Policy, Policyholders are entitled to receive the Covered Benefits as set forth in this Section.

2.1 **Hospitalization Covered Benefits.** The following Hospital services are covered by this Policy.

2.1.1 **Part A - Day Sixty-one (61) through Day Ninety (90) Coverage**. Part A Medicare Eligible Expenses for hospitalization are covered to the extent they are not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

2.1.2 **Inpatient Reserve Day Coverage**. Part A Medicare Eligible Expenses incurred for hospitalization are covered to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

2.1.3 **Exhaustion of Medicare Hospital Inpatient Coverage**. Upon exhaustion of the Policyholder's Medicare Hospital inpatient coverage (including lifetime reserve days), all of the Medicare Part A eligible expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment are covered, subject to a lifetime maximum benefit of an additional 365 days. The Provider shall accept the Plan's payment as payment-in-full and may not bill the Policyholder for any balance.

2.2 **Coverage of Blood.** Blood is covered under Medicare Parts A and B for the applicable Medicare Benefit Period for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

2.3 **Coverage of the Part B Medicare Coinsurance/Copayment Amounts**. Part B Medicare Coinsurance amounts, or in the case of hospital outpatient department services paid under a prospective payment system, the Medicare Copayment amounts of Medicare Eligible Expenses under Part B regardless of hospital confinement are covered, subject to the Medicare Part B Deductible.

2.4 **Part A Hospice and Respite Care Cost Sharing**. The cost sharing for all Part A Medicare Eligible Expenses for hospice and respite care is covered.

IDENTIFICATION OF COVERED ADDITIONAL BENEFITS

2.5 **Medicare Part A Deductible**. The Medicare Part A inpatient Hospital deductible amount per Medicare Benefit Period is covered.

2.6 **Skilled Nursing Facility Care Part A Coinsurance.** The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A are covered

2.7 Medicare Part B Deductible. The Medicare Part B deductible amount per calendar year regardless of Hospital confinement is covered.

2.8 Medicare Part B Excess Charges. Medicare Part B Excess Charges are covered for 100% of the difference between the Medicare Part B charges billed, not to exceed a charge limitation established by the Medicare program or state law including the Health Care Practitioner Medicare Fee Control Act, and the Medicare approved Part B charge.

2.9 Medically Necessary Emergency Care in a Foreign Country. Medically Necessary emergency care in a foreign country is covered to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency Hospital, physician and medical care received in a foreign country which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside of the United States subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

ADMINISTRATION OF COVERED SERVICES

2.10 Non-duplication of Benefits. This Policy provides the Covered Benefits specified in this Section 2 only to the extent that such Covered Benefits do not duplicate benefits provided by Medicare.

2.11 Computation of Benefit Days. In computing the number of inpatient benefit days a Policyholder has used, either the day of admission or the day of discharge shall be counted, but not both. The Policyholder agrees that the Plan shall not be held responsible for any costs incurred by the Policyholder and charged by a Hospital if the Policyholder does not vacate the Hospital room by the required time after being discharged by the attending physician.

2.12 Identification Card. The Identification Card issued by the Plan must be presented by the Policyholder to any Provider furnishing services or supplies under this Policy to the Policyholder.

SECTION 3. EXCLUSIONS

3. **EXCLUSIONS. THE FOLLOWING ARE NOT COVERED** by the Plan under this Policy except as may be specifically provided in Section 2:

3.1 **Covered Benefits and Cost Sharing not Set Forth in this Policy**. Covered Benefits which are not specifically set forth in Section 2 of this Policy are **NOT COVERED**.

3.2 **Services, Supplies, or Charges which are not Covered by Medicare or for which Benefits under Medicare have been Exhausted**. Services, supplies, or charges which are not covered by Medicare or for which benefits provided under Medicare have been exhausted are **NOT COVERED**, except as otherwise provided in Section 2 of this Policy.

3.3 **Not Medically Necessary and not Covered by Medicare**. Services, supplies, or charges covered under this Policy which are not covered by Medicare and are not Medically Necessary as determined by the Plan.

3.4 **Psychiatric Services, Supplies, or Charges not Covered by Medicare**. Services, supplies, or charges, not covered by Medicare, which are incurred due to confinement in a freestanding psychiatric facility are **NOT COVERED**.

3.5 **Medicare Opt-Out Provider Services**. Services covered by Medicare but provided to a Policyholder by a Medicare Opt-Out Provider, other than emergency and urgent care services, are **NOT COVERED**.

SECTION 4. PAYMENT, TERMINATION AND SUSPENSION OF COVERAGE

4. The following payment and termination provisions are applicable to this Policy. Please call the Customer Service Team at the telephone number on the back of your Identification Card if you have any questions on the information set forth in this Section 4.

4.1 Payment Provisions.

4.1.1 **Premium Rates**. The premium rates that apply to this Policy are approved by the Pennsylvania Insurance Department. Premium shall be remitted on a monthly basis to the Plan within the specified time frames set forth in this Policy. The Policyholder agrees to pay the applicable premium rate to the Plan in advance, as billed to the Policyholder. Upon payment of the premium, coverage will continue for one (1) month from the Effective Date of this Policy and from month to month thereafter until discontinued, terminated, or voided as provided in this Section.

4.1.2 **Adjustment of Premiums.** The Plan reserves the right to adjust applicable premium rates for all Policyholders covered under this Policy as approved by the Pennsylvania Insurance Department. The Plan will notify the Policyholder at the last address known to the Plan of any adjustment to premiums, not less than thirty (30) days prior to the effective date of such change, or as permitted by law.

4.1.3 **Time of Payment.** The first monthly premium must be paid before the Policy Effective Date, and succeeding premiums must be paid on or before the first day of each succeeding month in order for benefits to be provided, subject to the grace period provisions specified under this Policy in Section 4.1.4.

4.1.4 **Grace Period.** A grace period of thirty-one (31) days from the due date will be granted for payment of required premium. During the grace period, the Policy will remain in force. If required premium payment is not received by the end of the thirty-one (31) day grace period, the Policy will be terminated by the Plan on the last day of the grace period.

4.1.5 **Guaranteed Renewable/Premium Subject to Change.** This Policy is guaranteed renewable subject to the right of the Plan to terminate, cancel, non-renew or void coverage in accordance with Policy Sections 4.2.1 and 5.8, and may be renewed by payment of the applicable premium within the period set forth in Policy Sections 4.1.4 and 4.2.4 (as applicable). Subject to the approval of the Pennsylvania Insurance Department, the Plan may change the premium rate paid by all Policyholders covered under this Policy:

a) **Based on the Current Attained Age of the Policyholder**. Until the Policyholder is age 99, the premium rate will change each year based on the then attained age of the Policyholder. The Policy will automatically renew monthly based on the same attained age until January 1st of the subsequent year. At that time, the Policyholder's premium rate will be based on their attained age on January 1st of that year and will continue to be updated on January 1st each year thereafter. The Policyholder will receive thirty (30) days notice of any premium rate adjustment. If a Policyholder is age sixty-four (64) or under, the premium will not change except as set forth in Section 4.1.5 (b) below.

b) **Table of Rate Changes** b**ased on Classification, Age, Gender or Rating Area of the State.** The premium cannot be changed unless the Plan makes the same change for all Policyholders with the same classification, age, gender or rating area of the Commonwealth of Pennsylvania and provided such premium rate changes are approved by the Pennsylvania Insurance Department. If a rate change is made based on classification, age, gender or rating area, it will be effective following an annual approval by the Pennsylvania Insurance Department. The Policyholder will receive thirty (30) days notice of any premium rate adjustment.

NOTE: Schedules of rates may vary depending upon the Policyholder's Effective Date.

4.2 Termination Provisions.

4.2.1 **Termination of the Policyholder's Coverage under the Policy.** This Policy is guaranteed renewable except in the following instances:

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

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

i. If payment of the appropriate premium is not made when due, or during the grace period as set forth in Section 4.14 of this Policy.

ii. If a Policyholder in obtaining coverage or payment under the terms of this Policy has performed an act or practice constituting material misrepresentation.

4.2.2 **Health Status of Policyholder not Grounds for Termination**. The Plan will not terminate this Policy solely on the ground of health status of a Policyholder.

4.2.3 **Refund of Prepaid Premium.** If this Policy is terminated at the option of either party, the Plan shall refund to the Policyholder the amount of any unearned prepaid premium held by the Plan.

4.2.4 **Reinstatement following Nonpayment of Premium.** If any premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by the Plan or by any agent duly authorized by the Plan to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy, provided, however, that if the Plan or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by the Plan or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Policyholder and Plan shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

4.2.5 **Continuation of Benefits after Termination**. If a Policyholder with a *Continuous Loss is terminated for reasons other than material misrepresentation or voluntary termination, and the Policyholder incurs charges for his/her Continuous Loss while the Policyholder remains so disabled, the Policyholder shall be entitled to services under the terms of this Policy. Covered Benefits will be provided for charges incurred for the Continuous Loss until the earlier of: (1) the end of the Medicare Benefit Period as defined in Section 1.15 of this Policy; or (2) the exhaustion of Covered Benefits. Any such continuation of services after the date the Policy is terminated is conditioned upon the continuous total disability of the Policyholder, and the provision of documentation evidencing continued total disability as required by the Plan. Receipt of Medicare Part D benefits will not be considered in

determining continuous total disability. In no event will payment be made for charges incurred on or after the date the Policyholder is covered for Services which are similar under any other arrangement.

***NOTE**: For the purposes of this provision, "Continuous Loss" shall mean a condition commencing while this Policy is in effect, resulting from illness or injury as a result of which, and as determined by the Plan, the Policyholder is determined to be totally disabled.

4.3 Suspension and Reinstitution Of Coverage.

4.3.1 **Suspension of Coverage.** A Policyholder may request that Covered Benefits and premiums under this Policy be suspended under the following conditions:

a) The Policyholder is entitled to medical assistance and:

i) the Policyholder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (Medicaid); and

ii) the Policyholder notifies the Plan within ninety (90) days after the Policyholder becomes entitled to Medicaid.

The Policy will be suspended for up to a total of twenty-four (24) months.

b) The Policyholder is entitled to Medicare by reason of disability and is or becomes covered under an employer group health plan.

4.3.2 **Reinstitution of Coverage.** A Policyholder whose coverage is suspended and who loses Medicaid coverage or coverage under an employer group health plan may have coverage reinstituted. Upon reinstitution of coverage, the Policyholder will not be subject to any waiting period for pre-existing conditions. Coverage will be reinstituted effective as of the date of termination of either Medicaid coverage or coverage under an employer group health plan, provided the Policyholder notifies the Plan of the Policyholder's loss of entitlement to Medicaid or group coverage within ninety (90) days after the date of such loss and pays the Plan the applicable premium due. Coverage provided shall be substantially equivalent to coverage in effect before the date of suspension. Classification of premiums upon reinstitution shall be on terms at least as favorable as the premium classification terms that would have applied to the Policyholder had the coverage not been suspended.

SECTION 5. GENERAL PROVISIONS

5. GENERAL PROVISIONS.

5.1 Claims and Reimbursement. In order to receive coverage for services under this Policy, if the services are covered by Medicare, the Policyholder must furnish, or have furnished, an Explanation of Medicare Benefits. In most cases, the Provider will submit the Policyholder's claim. Additionally, the Plan may require other reports and records as necessary.

5.1.1 **Obtaining Coverage for Services Provided outside of Pennsylvania**. If services were provided outside of Pennsylvania and the Provider accepts Assignment, the Medicare carrier for that state will automatically submit the Policyholder's claim to the Plan. However, in order to collect benefits under this Policy when services are performed outside of Pennsylvania and the Provider does not accept Assignment, the Policyholder must notify the Plan.

5.1.2 **Medicare Part A and Part B Hospital Outpatient Services.** For services which supplement Medicare Part A and Hospital outpatient benefits which supplement Medicare Part B, the Policyholder must notify the Plan by mailing a copy of the Explanation of Medicare Benefits with the Policyholder's identification number written in the right-hand comer (the identification number can be found on the Identification Card) to:

Geisinger Gold Medicare Supplement
P.O. Box 8200
Danville, PA 17821-8200

5.1.3 **Notice of Claim.** Written notice of claim must be given to the Plan within twenty (20) days after the services covered under this Policy have been rendered to a Policyholder, or as soon thereafter as is reasonably possible. The Plan will not be liable for any claims under this Policy unless proper notice is furnished to the Plan that services covered under this Policy have been rendered to a Policyholder. Notice given by or on behalf of the Policyholder to the Plan that includes information sufficient to identify the Policyholder who received the service shall constitute sufficient notice of a claim to the Plan. A charge shall be considered incurred on the date a Policyholder received the service or supply for which the charge was made. The Policyholder can give notice to the Plan by writing to the Customer Service Team at Geisinger Gold Medicare Supplement, P.O. Box 8200, Danville, Pennsylvania 17821-8200, or by telephone to the Customer Service Team at the telephone number on the back of Identification Card.

5.1.4 **Claim Forms.** If the Policyholder (or if deceased, his/her personal representative) is required to submit a proof of loss for benefits under this Policy, it must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of claim under Section 5.1.3 of this Policy, will furnish to the Policyholder the forms typically required by the Plan for filing proofs of loss. If the Plan does not furnish such forms to the Policyholder within fifteen (15) days after the giving of such notice, the Policyholder shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss itemized bills for Covered Benefits, as described in Section 5.1.5 of this Policy.

5.1.5 **Proofs of Loss.** Claims cannot be paid until a written proof of loss is submitted to the Plan by the Policyholder, his/her personal representative, a Provider or any other party authorized to submit a claim on behalf of the Policyholder. Written proof of loss must be furnished to the Plan at its said office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal

capacity, later than one (1) year from the time proof is otherwise required. Proof of loss must include all data necessary for the Plan to determine benefits. Such information, in the form of an itemized bill, must include the following:

a) Full name of Policyholder for whom the services were rendered.

b) Date(s) of service.

c) Description of services rendered. If available, a diagnosis description and any coding that accompanies the services:
   i. Procedure/Service codes (and Modifiers)
   ii Diagnosis codes
   iii. location code

d) Charges for each service.

e) Servicing Provider/facility and address. If available, telephone number and Provider tax identification number.

Such information shall be submitted to the following address:

Geisinger Gold Medicare Supplement
P.O. Box 8200
Danville, PA 17821-8200

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that Covered Benefits have been rendered. Claim payments for benefits payable under this Policy will be processed immediately upon receipt of a proper proof of loss.

5.1.6 **Time of Payment of Claims.** Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss and in no case later than thirty (30) days after receipt of such proof of loss.

5.1.7 **Legal Actions.** No action in law or in equity shall be brought to recover on this coverage prior to the expiration of sixty (60) days after written proof of loss for Covered Benefits has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of claims for Covered Benefits is required to be furnished.

5.1.8 **Physical Examinations**. The Plan, at its own expense, shall have the right and opportunity to require a physical examination of the Policyholder when and as often as it may reasonably require during the pendency of a claim hereunder.

5.2. Method of Payment

5.2.1 **Supplementing Medicare Part A.** Payment for the services provided under this Policy will ordinarily be made to the Hospital, but the Plan may make payment directly to the Policyholder. In no event, however, may such payment be assigned without the consent of the Plan, unless otherwise required by law.

5.2.2 **Supplementing Medicare Part B**.

a) **Providers who accept Assignment.** Under the terms of Assignment, the Policyholder transfers to the Provider the right to both the Medicare Part B and the

Plan's payment under this Policy based on Covered Benefits specified on the claim. The Provider agrees to accept the Medicare Reasonable Charge set by the Medicare Part B Carrier as the total charge for Covered Benefits. The sum of the Medicare Reasonable Charge payments, eighty percent (80%) by Medicare Part B and twenty percent (20%) by this Policy (or in the case of Hospital outpatient charges under a prospective payment system, the applicable Medicare Copayment), constitute payment in full, except where maximums, deductibles, or other Medicare reductions are specified. The Plan reserves the right to make payment directly to the Provider.

b) **Providers Who Do Not Accept Assignment**. If the Provider does not accept Assignment, any difference between the Provider's charge and the combined Medicare Part B and the Plan's payment shall be the responsibility of the Policyholder except where prohibited by law.

c) **Providers Who Opt-Out of Medicare**. The Plan will make not make payment to a Medicare Opt-out Provider, except in cases where the Medicare Opt-out Provider provides emergency or urgent care services to a Policyholder who has not executed a private contract with that Medicare Opt-Out Provider. In such situations, the Plan will reimburse the Medicare Opt-out Provider twenty percent (20%) of the Medicare Reasonable Charge. The Plan reserves the right to make payment directly to the Policyholder.

5.3 Reports and Records. The Policyholder authorizes the Social Security Administration to furnish the Plan with medical or other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under this Policy. The Policyholder authorizes any person or organization which furnishes services or supplies to the Policyholder to provide the Plan with information necessary to process claims under this Policy.

5.4 Coordination of Benefits. All services provided under this Policy are subject to this provision, and will not be increased by virtue of this provision.

5.4.1 **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 Policyholders (or others covered under the program):

i. group sponsored benefit coverage;
ii. group-type health benefits coverage, whether insured or uninsured, which is not available to the general public;
iii. 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). It also does not include any health benefits program that by law the benefits exceed those of any private insurance program or any other non-governmental program;
iv. individual health benefits coverage.

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 Policy that provides Covered Benefits or benefits to Policyholder 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 Policyholder:

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 Benefits 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 covered person for whom the claim is made. The term Allowable Expense does not include coverage for items **NOT COVERED** under this Policy. When This Plan provides Covered Benefits, 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 covered person'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.

5.4.2 **Applicability.**

a) This Coordination of Benefits (COB) provision applies to This Plan when a Policyholder has health care coverage under This Plan and one (1) or more other Programs.

b) If the Policyholder 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 Benefit 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.

5.4.3 **Order of Benefit Determination Rules.**

a) **General.** When a Policyholder receives Covered Benefits by or through This Plan, or is otherwise entitled to claim benefits from This Plan, and the Covered Benefits 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 covered person as a Policyholder are Primary to those of the Program which covers the covered person as a Family Dependent.

2) **Active/Inactive Employee.** A Program which covers a Policyholder as an employee who is neither laid off nor retired (or as that employee's dependent) is Primary to a Program which covers that Policyholder 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 (2) is ignored.

3) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Program which covered a Policyholder longer is Primary to the Program which covered that Policyholder for a shorter time.

5.4.4 **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 Benefits 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 Benefits 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.

5.4.5 **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. It 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.

5.4.6 **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.

5.4.7 **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 Benefits which should have been paid by the Primary Plan, This Plan may recover the excess or the reasonable cash value of the Covered Benefits as applicable, from one or more of:

a) the persons it has paid;

b) insurance companies; or

c) other organizations.

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

5.5 Duplicate Medicare Supplement Coverage. If any services to which a Policyholder is entitled under this Policy are also provided in part or in full by another Medicare supplement agreement,

the Plan may treat this Policy as void and without effect.

5.6. Subrogation. The Plan 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 Plan under this Policy. The Policyholder shall do nothing to prejudice the subrogation rights of the Plan. The Plan may recover benefits amounts paid under this Policy under the right of subrogation to the extent permitted by law.

5.7 Disclaimer of Liability. It is expressly understood that the Plan (as a corporation or otherwise) does not furnish any health service benefits. The Plan contracts with professional providers of care for the Covered Benefits received by Policyholders under this Policy. The Plan (as a corporation or otherwise) is not, in any event, liable for any act or omission of the professional personnel of any medical group, hospital, or other provider of services.

5.8 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 Policy or to deny a claim commencing after the expiration of three (3) years from the date of issue of this Policy.

No claim for loss incurred from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Policy Effective Date of this Policy.

Material misrepresentations will, at the option of the Plan, render this Policy void from inception, provided such material misrepresentations are discovered by the Plan within three (3) years of the Policy Effective Date. In the event the Plan elects to void this Policy, the Policyholder will forfeit any charges paid to the extent of any liability incurred by the Plan.

5.9 Misstatement of Age. If the age of the Policyholder has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

5.10 Conformity with State Statutes. Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Policyholder resides as of such Effective Date, is hereby amended to conform to the minimum requirements of such statutes.

5.11 Release of Information. All personally identifiable information about individual Policyholders ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164) and also including applicable HITECH provisions. In accordance with those standards, the Plan may use and disclose Protected Health Information to facilitate payment, treatment and health care operations as described in the Plan's Notice of Privacy Practices (NPP). Copies of the Plan's current NPP are available on the Plan's internet site, or from the Plan's Privacy Office.

5.12 Entire Agreement; Changes. This Policy, the Policyholder's Application, the Enrollment Letter and the Identification Card constitute the entire agreement between the Policyholder and the Plan. No agent or representative of the Plan, other than an executive officer of the Plan, may otherwise change this Policy or waive any of its provisions. All statements made by a Policyholder shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Policy, unless it is contained in a written instrument signed by and furnished to the Policyholder.

5.13 Change of Residence. If the Policyholder establishes a residence outside the United States, services, as defined in this Policy, provided outside the United States shall not be available.

5.14 Revision of Policy or Rates. The Plan, subject to the approval of the Insurance Department of the

Commonwealth of Pennsylvania, may:

a) alter or revise the terms of this Policy by endorsement or required notice of change issued by the Plan; and/or
b) modify applicable premium rates.

Any such alteration or revision of the terms of the Policy sha11 become applicable for all Policyholders on the effective date of the alteration or revision, whether or not the Policyholders have paid premium rates in advance. In the event of a modification of the premium rates, the Policyholder shall be notified in advance of the new premium rate and the effective date. Any notice shall be considered to have been given when mailed to the Policyholder at the address on the records of the Plan.

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

Geisinger Gold Customer Service Team
M.C. 3229
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 Policyholder will be sent to the Policyholder's last address known to the Plan.

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

5.17 Clerical Error. Clerical error in keeping any record pertaining to the coverage under this Policy will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

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

5.19 Governing Law. This Policy is entered into and 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 Policy shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.