Troy Area School District

Employee Benefit Plan

and

SUMMARY PLAN DESCRIPTION

Effective Date:

January 1, 2013

The following information is provided to you in accordance with the Section 125 of the Internal Revenue Code, as amended, and summarizes all benefits offered under the Troy Area School District Employee Benefit Plan.

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1. INTRODUCTION

The Troy Area School District values their employees, retirees and their families and we are pleased to provide you with a comprehensive and cost effective benefit package.

This document includes a description of the Troy Area School District Employee Benefit Plan. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants by providing the following benefit programs:

Appendix # 1	Blue Card PPO - Active Employees and Retirees - Medical (including prescription drugs) – Self-insured with Administrative Services Provided by First Priority Life
Appendix # 2	Traditional Indemnity - Medical (including prescription drugs) – Self-insured with Administrative Services Provided by First Priority – Option is no longer available to new enrollees
Attachment # 1 *	Delta Dental – Administrative Services Only
Attachment # 2*	Blue Cross Blue Shield – Davis Vision (available to Support Staff only)
Attachment # 3*	Flexible Spending Account Plan – (including medical and dependent care spending accounts) - Self-Insured with Administrative Services Provided by CBIZ
Attachment # 4*	Troy Area School District Premium Sharing Requirements – New Hire or Open Enrollment Packet

Your coverage under the Plan will take effect for an eligible Employee or Retiree and designated Dependents when the Employee or Retiree and such Dependents satisfy all of the eligibility requirements of the Plan.

Troy Area School District fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with appropriate notification requirements eligible employees.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All eligible employees contribute towards medical benefits (including prescription drugs) and vision (Support Staff Personnel pay full premium if elected) coverage on a pre–tax basis through salary reduction.

*A schedule of employee premium contribution requirements can be found in Attachment # 4 and has been previously distributed to you. You may request a copy by submitting a written request to the Business Office.

The Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code Section 125, and regulations issued shall be interpreted to accomplish that objective.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Insurance Company.

*A copy of each booklet, summary or other governing document is addressed in this document as Attachments # 1 through # 4 noted above. Copies of all attachments for the Plan have been previously delivered to you and are on file at the Troy Area School District's Business Office and are available to you with your written request.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force.

The Plan also covers the employees in accordance with their collective bargaining agreements currently in place:

Collective Bargaining Unit	Group
Troy Area Education Association	("TAEA") / PSEA
Troy Area Educational Support Personnel Association	("ESPA") / PSEA

Information regarding eligibility and participation can be found in the current collective bargaining agreements.

Troy Area School District fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with the appropriate required notification requirements pursuant to eligible employees' collective bargaining agreements.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

When this Summary Plan Description uses the term "Plan Sponsor", it is referring to the Troy Area School District which sponsors the Plan.

If anything in the Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator in the Business Office.

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, and the Insurance Company with his or her current address. If required by the Insurance Company, each employee who is a Participant shall be responsible for providing the Insurance Company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Insurance Company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

Purpose of the Plan Document

Troy Area School District is providing this document to address certain information that may not be addressed in the attached group insurance contracts. This document, together with the group insurance contract issued by the Insurance Company, is the Plan document required by Section 125 of the Internal Revenue Code. This Plan document is not intended to give any substantive rights to benefits that are not already provided by the attached group insurance contracts.

2. DEFINITIONS

Active Employee is an employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Benefit Period –

Coverage	Plan/Policy Year
Medical (including prescription drugs), Dental, Vision and Flexible Spending Account Plan (including Medical and Dependent Care expense accounts)	7/1 to 6/30

Benefit Schedule means a document which describes the terms and benefits to be administered by First Priority Life which is marked as Appendix 1 and 2, attached hereto and incorporated herein by reference. The Benefit Schedule describes the Covered Services, Copayments, Coinsurance, Deductibles and other financial requirements of the Participants, as well as any limitations, exclusions and other provisions of the health benefits program.

BLUECARD means a program, which allows a Participant to access Covered Services from Providers located outside the geographic area serviced by First Priority Life and are participating with their local Blue Cross and/or Blue Shield Licensee. The local Blue Cross and/or Blue Shield Licensee, which serves the geographic area where the Covered Service is provided is referred to as the on-site Blue Cross and/or Blue Shield Licensee (Host Blue).

Claims Fiduciary means First Priority Life shall act as a fiduciary under the laws of the Commonwealth of Pennsylvania in connection with the exercise of its responsibilities regarding benefit determinations and reviews of denied claims for benefits under the health benefits program. Refer to Exhibit C Complaint and Grievance Review Procedure.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as may be amended from time to time.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), an individual health insurance policy, and Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental benefits.

Dependent – Medical means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Benefits are available until the end of the month in which the attainment of age 26 is reached.

Dependent – Dental and Vision means any individual who is a (a) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (b) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the calendar month in which the dependent attains age 23 (limiting age) (verification of full-time status is required); (c) a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child's age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or by the end of the calendar month in which the dependent attains age 23 (limiting age) (verification of full-time status is required) if the child was age 19 or over and enrolled as a full-time student at the date of such commencement; (e) any child of a participant who does not qualify as a dependent under subsections (b), (c), or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order, including a Qualified Domestic Relations Order or National Medical Child Support Order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

Newborn children of any Enrollee for thirty-one (31) days after birth.

At any time, the Plan may require proof that a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Eligible Employee means any full or part-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common-law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor by the Employer or Affiliated Employer and any other common-law employee not described above is not an Employee and is not eligible to participate in this Plan. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law employee" of the Employer or Affiliated Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as a common-law employee by the Employer or Affiliated Employer.

Employer means the School District, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of Troy Area School District.

Enrollment Period means such period of time when you are initially eligible for benefits. Once you have made an election for benefits under this plan, your election will remain in place until you wish to make a change due to a Special Enrollment Period or Change in Election Event occurs. You may also make changes to your elections at Open Enrollment each year. You must re-enroll in the Flexible Spending Account Plan each year at open enrollment.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Family Coverage means coverage for the Participant and one or more of the Participant's Dependents.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

National Medical Child Support Order means the District will also provide benefits as required by any medical child support order, as provided by law under the National Medical Support Notice ("NMSN"). The Plan will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries.

Participant means an Eligible Employee who has met the requirements of component benefits in the Plan and participates in the Plan or an eligible Dependent.

Plan means Troy Area School District Employee Benefit Plan, which is a benefits plan for eligible employees of Troy Area School District and is described in this document.

Plan Administrator means the individual named in the General Information about the Plan Section of this document. The Plan Administrator is not First Priority Life.

Plan Year means a twelve (12) consecutive month period that commences and ends on a date selected by the Sponsor and shown in the General Information Section of this Summary Plan Description.

Pre-Tax Salary Reduction means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee's behalf directly to the Insurer to pay for the level of health or dental coverage elected by the Employee for himself and his Dependents. The maximum Employer pre-tax contributions which can be made hereunder in consideration of a Salary Reduction cannot exceed the cost of the level of coverage elected by the Participant under the medical benefit or dental program reduced by any Employer Premium Contribution.

Qualified Beneficiary under COBRA means an individual, on the day before a COBRA Qualifying Event, is a Spouse or dependent child of an Employee and who is covered under the medical, dental, vision or flexible spending plan components. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee covered by the Plan.

Qualifying Event under COBRA means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to a part-time Employee; (d) divorce or legal separation of an Employee from his or her Spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the medical, dental, vision or flexible spending account programs.

PSERS means the Pennsylvania Public School Employees' Retirement System.

Retiree means an Employee that has submitted a valid written resignation to the Board of Directors pending retirement and has submitted to the Pennsylvania Public School Employees Retirement System the official application for retirement benefits. Benefits available are medical (including prescription drugs) and dental and are paid at the expense of the Retiree. Support Staff Retirees also have the option to purchase an individual policy for vision benefits to be paid at the expense of the Retiree. Benefits are available until the Retiree attains the age of 65 and is eligible for Medicare. Please see the Business Manager who acts as the Plan Administrator for more information regarding retiree group insurance coverage and associated costs.

Service Area for the medical plan means the following thirteen (13) Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

Sponsor means the employer identified in the General Information Section of this Summary Plan Description. Sponsor also means any successor entity assuming the obligations created in this Plan. Solely for the purposes of nondiscrimination testing under Code Section 125, the Sponsor shall include all entities which are treated as an Affiliate.

Spouse means the description set forth in the Defense of Marriage Act ("DOMA") and the word "marriage" means a legal union between one man and one woman as husband and wife, the word "Spouse" refers only to a person of the opposite sex who is a husband or wife.

At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Spouse or Dependent as defined by this Plan.

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

3. GENERAL INFORMATION ABOUT THE PLAN

Employer Name: Troy Area School District

Plan Name: Troy Area School District
Employee Benefit Plan

Employer Address: 30 Taylor Street
Troy, PA 16947

Employer's Telephone Number: 570-297-2750

Plan/Policy Years: July 1st to June 30th

Employer's Federal Tax Identification Number: 23-1667986

Plan Sponsor: Troy Area School District

Plan Administrator/Named Fiduciary
(Dental, Vision and Flexible Spending Account Plan): Payroll Specialist
Troy Area School District
30 Taylor Street
Troy, PA 16947

Plan Administrator/Named Fiduciary
(Medical (including prescription drugs): Northern Tier Insurance Consortium

First Priority Life and BCNEPA are fiduciaries with regard to eligibility for and benefit claims in the medical programs offered under the Plan.

Agent for Service of Legal Process: Troy Area School District
30 Taylor Street
Troy, PA 16947
District Solicitor

Funding Medium and Type of Plan Administration:

The insurance companies, not Troy Area School District, are responsible for paying claims with respect to these programs. Troy Area School District shares responsibility with the insurance companies for administering these program benefits.

The following benefits under the Plan are fully insured through insurance contracts:

Vision Insurance:	Blue Cross Blue Shield - Davis Vision

The insurance companies, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies for administering these program benefits.

The following benefits under the Plan are self-funded and paid through pre-tax salary reductions and/or the general assets of the employer:

	Administrative Services Provided by:
Medical (including prescription drugs):	First Priority Life
Dental:	Delta Dental
Flexible Spending Account Plan:	CBIZ

Insurance premiums for employees and their eligible family members are paid in part by Troy Area School District out of its general assets and in part by employees' pre-tax salary reductions. A schedule of required employee pre-tax contributions for coverage for the current Plan Year can be found in Attachment # 4.

The administrative service provider, not Troy Area School District, is responsible for paying claims with respect to the self-funded programs. Troy Area School District shares responsibility with the administrative services provider for administering these benefits.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

4. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Eligible Classifications

Eligibility for benefits includes coverage for Employees, Spouses, eligible Dependents and Retirees and their Spouses.

Enrollment/Termination of Participants – First Priority Life

At the direction of the school district, First Priority Life shall enroll as Participants hereunder those Eligible Persons who have been specified to First Priority Life by the school district for enrollment. Coverage hereunder shall commence for individual Participants on the dates specified in writing or via other documented communication to First Priority Life by the school district. The school district shall promptly submit to First Priority Life enrollment data for individual Participants, and First Priority Life shall provide Identification Cards/Card Carriers for distribution to Participants. Identification Cards must be presented to Providers when services are requested.

Eligible full-time employees pay for a portion of the premiums for medical (including prescription drugs) and Support Staff Personnel pay the full premium for vision coverage. To find out your required premium contribution, please see Attachment # 4.

Component Benefit	Eligibility
Medical (including prescription drugs) Dental Vision (Support Staff only) Flexible Spending Account Plan	**Full-time or Part-time Eligible Employees** who work 5 or more hours per day.

Dependent – Medical means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Benefits are available until the end of the month in which the attainment of age 26 is reached.

Dependent – Dental means any individual who is a (a) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (b) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the calendar month in which the dependent attains age 23 (limiting age) (verification of full-time status is required); (c) a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child's age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or by the end of the calendar month in which the dependent attains age 23 (limiting age) (verification of full-time status is required) if the child was age 19 or over and enrolled as a full-time student at the date of such commencement; (e) any child of a participant who does not qualify as a dependent under subsections (b), (c), or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order, including a Qualified Domestic Relations Order or National Medical Child Support Order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

Newborn children of any Enrollee for thirty-one (31) days after birth.

At any time, the Plan may require proof that a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Retiree means an Employee that has submitted a valid written resignation to the Board of Directors pending retirement and has submitted to the Pennsylvania Public School Employees Retirement System the official application for retirement benefits. Benefits available are medical (including prescription drugs) and dental and are paid at the expense of the Retiree. Support Staff Retirees also have the option to purchase an individual policy for vision benefits to be paid at the expense of the Retiree. Benefits are available until the Retiree attains the age of 65 and is eligible for Medicare. Please see the Business Manager who acts as the Plan Administrator for more information regarding retiree group insurance coverage and associated costs.

Spouse means the description set forth in the Defense of Marriage Act ("DOMA") and the word "marriage" means a legal union between one man and one woman as husband and wife, the word "Spouse" refers only to a person of the opposite sex who is a husband or wife.

Component Benefit	When Participation Begins
Medical (including prescription drugs) Dental Vision (Support Staff only) Flexible Spending Account Plan	Date of Hire

You may become a participant on your participation date, provided you properly submit an election form to the Plan Administrator prior to that date and during the period designated by the Plan Administrator as your initial "enrollment period" and provided Troy Area School District determines you have the status of an active employee of Troy Area School District on your participation date.

After you complete an initial election form, your initial benefit election will remain in effect indefinitely unless you need to change your elections for certain other reasons or until you make a new benefit election by requesting, completing and submitting a new election form to the Plan Administrator during an election period or for Special Enrollment Periods.

Buy-Out Option

Eligible Employees who can show evidence of other available group health plan coverage may be entitled to a buy-out option. Please see the Business Manager for eligibility and the amount of the buy-out.

Participant/Spouse Employment

If both you and your Spouse are eligible employees of Troy Area School District you may be covered under the Plan as a Dependent of your Spouse.

Leased or Temporary Employment

Leased employees, persons classified by Troy Area School District as temporary employees of Troy Area School District (as determined by Troy Area School District) are not eligible for benefits in the Plan. A person who is characterized by Troy Area School District as a leased employee of Troy Area School District, but who is later characterized by a regulatory agency or court as being an Employee, will not be eligible for the period during which they are characterized as a leased employee by Troy Area School District.

Special Enrollment Periods

Special Enrollment Rights – Health Insurance Portability and Accountability Act ("HIPAA"). If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in Troy Area School District Employee Benefits Plan medical plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 30 days after the applicable event. Furthermore, whether you are participating or not, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and newly-acquired Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights – Children's Health Insurance Program Reauthorization Act - 2009. If you and your dependents are eligible but not enrolled for coverage under your employer's group health plan you may enroll in two circumstances: 1) you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; and 2) you or your dependent becomes eligible for a Subsidy under Medicaid or CHIP (if offered by your state). You or your dependent(s) must request coverage within **60 days** after you or your dependent is terminated from, or determined to be eligible for such assistance.

Change in Election Events

If a Change in Election Event (including a Change in Status) occurs, you must inform the Administrator and complete a Change in Status Form within 30 days of the occurrence.

Generally, you cannot change your election to participate in the medical (including prescription drugs), vision (available to support staff personnel who pay full premium) and flexible spending account components of the Plan or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule). Your election will terminate if you are no longer working for the school district. Of course, you can change your elections for benefits and salary reductions prior to July 1st during open enrollment for medical (including prescription drugs), vision (support staff personnel pay full premium) and flexible spending account plan benefits but that will apply only for the upcoming Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events.* "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgments, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. *(Change in Status, Cost and Coverage* are defined below). However, the Change in Election Events do not apply to all benefits in the Plan, exclusions apply. Examples are described below for each such Event.

1. **FMLA Leave.** You may change an election under the Plan upon commencement of and return, if coverage was revoked, from FMLA leave.

2. **Change in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:
   - A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). *"Spouse"* means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code *(Code)*;
   - A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code:
   - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefit;
   - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age, student status, or similar circumstance); and
   - A change in your, your Spouse's or your Dependent's place of residence.

3. **Change in Status-Other Requirements**. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in his/her sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are

consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee -plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or Dependent elect COBRA continuation coverage under the Employer's plan for any reason other than divorce, annulment or legal separation, or your child's ceasing to be a Dependent, and you remain a Participant under the terms of this Plan, you may be able to increase your contribution to pay for such coverage.

- *Gain of Coverage Eligibility under another Employer's Plan.* For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. See the Plan Administrator or Benefits Coordinator to obtain cost information for Troy Area School District's Plan.

4. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

5. **Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

6. **Change in Cost.** If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.

7. **Change in Coverage.** You may also change your election for the Plan if one of the following events occurs:
   - *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage, then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop

coverage but only if there is no option available under the plan that provides similar coverage.

- *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the component Plan.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you lose coverage under any group health coverage sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election under another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

8. **Dependent Care.** You may make an election change to the contribution to your Dependent Care FSA that is due to a change in the provider of dependent care. You may also make an election change to the contribution to your Dependent Care FSA that is due to a change in cost of dependent care; so long as the provider of dependent care is not your relative.

If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

Note that changes such as Automatic Small Cost Changes, Significant Cost Increases (with or without loss of coverage), Significant Coverage Curtailment, Addition or Elimination of Benefit Package Option or Change in Coverage under Other Employer's Plan does not permit changes to your Flexible Spending Account Plan accounts.

Benefits for Adopted Children / Guardianship Agreements

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption or a child under guardianship under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Employee Participants who currently cover eligible dependents under a Guardianship Agreement will be required, upon enrollment and subsequent requests, to show proof of continued guardianship in order to continue coverage in the Plan for dependent child(ren).

Termination of Participation

Your participation and the participation of your eligible family members (if applicable) in the Plan's benefits will terminate at the end of the month after termination of employment.

Coverage may also terminate if:

- Your hours drop below any required hourly threshold;
- You submit false claims;
- Troy Area School District discontinues the plan for any reason;
- If you are covered under a collectively bargained agreement that has changed eligibility for benefits under contract;
- The end of the month following the day on which an eligible dependent ceases to be an eligible dependent; or
- Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer.

For all retroactive terminations, the school district will be responsible for claims incurred after the termination if the termination was

processed retroactively. Administrative fees for retroactively terminated participants are fully refundable.

Employees on Military Leave

Regardless of any provision described above, if you take a leave of absence from employment with Troy Area School District because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for you and your covered Spouse or dependents.

You will be required to pay for such coverage in an amount determined under USERRA. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share of dependent coverage costs, if any.

Such coverage will end on the earlier of:

1. the last day of the 24-month period beginning on the date your absence begins; or
2. the day after the date on which you fail to apply for or return to a position of employment with Troy Area School District.

Please contact the Payroll Specialist if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, or Dependent(s) prospectively without notice for cause or if you, your Spouse, or Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or Dependent(s) commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, the Plan Administrator may terminate your, your Spouse's, or Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice. Failure to inform the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, as applicable, that you, your Spouse, or Dependent(s) is covered under another plan constitutes fraud under the Plan.

National Medical Child Support Orders

With respect to benefits, Troy Area School District Employee Benefit Plan will also provide benefits as required by any medical child support order, as provided by law under the National Medical Support Notice ("NMSN"). The Plan will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries. The Payroll Specialist will ask the Employee to submit an enrollment form to obtain coverage and will administer the provision of benefits under the Plan according to the NMSN, to the extent required by law.

In order for this Plan to recognize a National Medical Support Order it must satisfy the following criteria:

1. It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent Child of a covered Employee; and

2. The order must specify:

    a. the name and address of the Employee or their designee;
    b. the name and mailing address of each dependent child covered by the order;
    c. a reasonable description of the type of coverage afforded by the Plan;
    d. a beginning period for which the order applies; and
    e. the name and address of each Alternate Payee, which means the Spouse, former Spouse, legal guardian of the dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee.

The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee an each

Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or Alternate Payee shall promptly notify the Plan Administrator in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later.

Any order that requires the Troy Area School District Employee Benefit Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a National Medical Support Order.

Please see the Payroll Specialist for questions regarding National Medical Support Orders.

5. COBRA RIGHTS

"Continuation Coverage" means your right your Spouse's and Dependents' right, to continue the same coverage under any medical benefit plan coverage that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under *COBRA* (Consolidated Omnibus Budget Reconciliation Act of 1985). Troy Area School District is subject to COBRA.

Initial COBRA Notification

The Employee (if he or she is covered under the Plan) and the Employee's covered Dependent Spouse must receive a written General Notice explaining COBRA continuation coverage rights under the Plan. The General Notice will be furnished not later than the earlier of:

• Ninety days from the date on which the Employee first becomes or his or her Dependent Spouse first becomes covered under the Plan, or

• The first date after coverage starts that the Employee or his or her Dependent Spouse or Dependent Child is required to be furnished with a qualifying event notice.

The General Notice requirement will be satisfied by furnishing a single, written General Notice addressed to both the covered Employee and his or her covered Dependent Spouse, if:

• Based on the most recent information available to the Plan, the Employee and his or her Dependent Spouse reside at the same location, and

• The Dependent Spouse's coverage under the Plan first begins on or after the date that the Employee's coverage under the Plan first begins but not later than the date that the Employee must be provided with materials explaining his or her right to the continuation coverage provided under the Plan.

Otherwise, separate mailings will be made to the covered Employee and his or her covered Dependent and/or Spouse.

The General Notice will be delivered by first class mail. The General Notice will be considered "furnished" as of the mailing date.

Basic COBRA Continuation Coverage Rights

If Troy Area School District amends the medical benefits for active employees and their family members during your COBRA Coverage period, your COBRA Coverage under the plan will be amended in the same manner.

If you are an Employee covered by the Troy Area School District Employee Benefit Plan, you have the right to choose this continuation coverage if you, your Spouse or a Dependent child loses group health coverage because of any of the following Qualifying Events:

- termination of your employment (other than by reason of gross misconduct);
- reduction of your work hours;
- your death;
- divorce or legal separation from or death of your Spouse;
- you or your Spouse becoming enrolled to receive Medicare (under Part A, Part B, or both) benefits; or
- Dependent child ceases to be a "Dependent child" under the Troy Area School District Employee Benefit Plan.

For a Qualifying Event other than a change in your employment status or death, it will be your obligation to inform the Troy Area School District Employee Benefit Plan, Plan Administrator of the qualifying event within *60 days* of its occurrence. The Administrator, in turn, will furnish you (and your Spouse, as the case may be) with separate, written options to continue the coverage(s) provided at stated premium costs with respect to each health plan in which you are participating. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage. Similar rights may apply to Spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

The law requires that former employees and beneficiaries be afforded the opportunity to maintain continuation coverage for 18 months if coverage is lost due to termination of employment or reduction in hours. This 18-month period may be extended to 36 months if a beneficiary experiences a second qualifying event (such as death, divorce, legal separation, Medicare entitlement, or no longer meeting the description of a dependent). Qualified beneficiaries may also be eligible for 36-month continuation coverage if group coverage has been lost for any reason other than termination of employment, reduction in hours or bankruptcy.

The 18 months may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) and the Plan Administrator is notified of that determination within 60 days. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond 3 years from the date the event that originally made a qualified beneficiary eligible to elect coverage.

A summary of the length of your coverage periods follows:

Qualifying Event Resulting in a Loss of Coverage	Maximum Coverage Period
Employee's reduced work hours, except for a reduction in hours in connection with Family and Medical Leave	18 months
Employee's termination (except for gross misconduct) or retirement	18 months
Employee's death, divorce or legal separation of the employee and Spouse	36 months
Dependent child's loss of eligibility (for example, by reaching the age limit, no longer being a full-time student, getting married or becoming a full-time employee)	36 months
Dependent's loss of coverage because employee enrolls in Medicare	36 months

In no event will COBRA continuation coverage last beyond 36 months from the date of the original qualifying event that made a qualified beneficiary eligible to elect COBRA continuation coverage.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

1. Troy Area School District no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have (Troy Area School District must limit pre-existing exclusion period to no more than 12 months (18 for a late entrant)). A plan's pre-existing conditions exclusion period will be reduced by each month that you and your family had continuous health coverage (including COBRA continuation coverage with no break in coverage greater than 63 days). Please note that pre-existing condition requirements have been eliminated for children under the age of 19 through the Patient Protection and Affordable Care Act (also known as Health Care Reform). Pre-existing condition requirements for all participants will be eliminated in 2014;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate the coverage of a Plan Participant or beneficiary not receiving continuation coverage (such a fraud).

The Trade Act of 2002 and COBRA

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals typically include those who have been displaced due to foreign competition). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. Please see the Payroll Specialist for increases

to the 65 percent through federal extension of this tax credit.

COBRA Premium Payments

You do not have to show that you are insurable to choose continuation coverage. Qualified beneficiaries must pay for the COBRA continuation coverage they elect. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium. However, during an extension of coverage for disability, you and your qualified beneficiaries may be required to pay 150% of the "cost of coverage" under the medical plan.

There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided by the insurance carrier under Troy Area School District Employee Benefit Plan.

The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the event, or any representative acting on behalf of the qualified beneficiary must provide notice of the occurrence of either of these qualifying events to Troy Area School District within 60 days after the latest of:

- The qualifying event date;
- The qualified beneficiary's loss of coverage date under the Plan due to the qualifying event; or
- The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Send all premium payments for COBRA coverage to the COBRA Administrator. As of the date of the SPD, the COBRA Plan Administrator is School Claims Services, LLC, unless you are notified by Troy Area School District of a different COBRA Administrator.

Oral notice, including notice by telephone is not acceptable. The notice must be in writing and be mailed to this address:

School Claims Services, LLC
P.O. Box 812
New Cumberland, PA 17070

1-866-403-7700

Satisfactory written notice must be postmarked no later than the last day of the required 60-day notice period. Otherwise, COBRA continuation coverage does not have to be offered.

If there are any changes to your marital status, you or your Spouse's address(es), or the Dependent status of any of your children under the Plan, please notify the Plan Administrator immediately.

If you have any questions about your COBRA rights, please contact your Plan Administrator at Troy Area School District, Payroll Specialist, 30 Taylor Street, Troy, PA 16947 570-297-2750.

COBRA Notice Procedures

The notice must include the name of the Plan, the name, address, and member number of the covered Employee, the name(s), address (es), and member number(s) of the qualified beneficiary (ies), a description of the qualifying event, and the date on which the qualifying event occurred. If the qualifying event is a divorce, the notice must include a copy of the divorce decree. The notice must also include any other information that Troy Area School District, in its sole discretion, may require.

Within 30 days of receiving the timely, written notice, Troy Area School District will forward the notice to the COBRA Administrator. Within 14 days of being notified of the qualifying event, the COBRA Administrator will send COBRA information to the covered Employee, the qualified beneficiary, or other individual with respect to the event.

If it is determined that an individual is not entitled to COBRA continuation coverage, he or she will be provided with a Notice of Unavailability of Continuation Coverage explaining why the individual is not entitled to continuation coverage. If it is determined that an individual is a qualified beneficiary entitled to COBRA continuation coverage, he or she will be provided

with an Election Notice.

Notice is required when an SSA determination of disability occurred before or occurs during an 18-month period of continuation coverage.

To obtain the 11-month extension of coverage, there are special deadlines and special procedures for providing notice of the SSA disability determination. The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the event, or any representative acting on behalf of a qualified beneficiary must provide notice about the occurrence of the determination. The notice must be provided before the end of the first 18 months of COBRA continuation coverage and within 60 days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date that the covered Employee's employment ends or reduction in hours of employment occurs;
- The date on which coverage is lost due to termination of the covered Employee's employment or reduction in hours of employment; or
- The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Notice is required when certain second qualifying events occur during an 18-month period of continuation coverage. Those second qualifying events are: the covered Employee's death, the covered Employee's divorce or legal separation, the covered Employee becoming entitled to Medicare benefits (Part A, Part B, or both), or a Dependent Child ceasing to be a Dependent Child under the terms of the Plan.

A deadline and special procedures apply to providing this notice. The covered Employee, another member of his or her family who is a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the qualified beneficiary must provide notice about the occurrence of a second qualifying event within 60 days after the latest of:

• The date on which the second qualifying event occurs;

• The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the second qualifying event; or

• The date on which the qualified beneficiary is informed through the furnishing of this document or the initial General Notice, of both the qualified beneficiary's responsibility to provide notice and the Plan's procedures for providing notice.

Oral notice, including notice by telephone is not acceptable. The notice must be in writing and mailed to the following address:

School Claims Services, LLC
P.O. Box 812
New Cumberland, PA 17070

1-866-403-7700

Satisfactory written notice must be postmarked no later than the last day of the required 60-day notice period. Otherwise, COBRA continuation coverage does not have to be offered.

The notice must include the name of the Plan, the name, address, and member number of the covered Employee, the name(s), address(es), and member number(s) of the qualified beneficiary(ies), a description of the second qualifying event, and date on which the second qualifying event occurred. The notice must also include any other information that Troy Area School District, in its sole discretion, may require.

Within 14 days after satisfactory written notice is received, if it is determined that an individual is not entitled to an extension of COBRA continuation coverage, the individual will be provided with a Notice of Unavailability of Continuation Coverage explaining why the individual is not entitled to the extension.

Consequences of Providing Incomplete Notices

The Plan will not reject an incomplete notice as untimely if the notice is provided within the time limits specified above and contains enough information to enable the identification of the Plan, the covered Employee and qualified beneficiary(ies), the qualifying event or SSA disability determination, and the date on which such event or determination occurred. However, the covered Employee, a qualified beneficiary with respect to the event, or a representative acting on behalf of the covered Employee or qualified beneficiary will be required to supply the missing information. A deficient notice will be rejected and all rights to continuation coverage under the Plan will be lost if, following a request for more complete information, the covered Employee, qualified beneficiary, or representative fails to provide the requested information, in writing, postmarked no later than the 30th day after the date of the request.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

6. FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)

Benefit and Service Continuation during Family Leave

- During the period of your leave under this Plan, the Troy Area School District Employee Benefit Plan will continue your medical benefits, as required by law. This means the Troy Area School District will continue your benefits on the same basis as if you were continuing your employment.

- Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs), vision, and flexible spending account plan coverage during their leave. Premiums can be paid on a pre-tax basis prior to the leave, during the leave with post-tax dollars, or upon return from leave with pre-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

  If you elect to cease participation in the flexible spending account plan, medical (including prescription drugs), or vision expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

  If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above. However, you have two choices regarding the flexible spending medical account:

  - You can elect to have your contributions resume at the level in effect prior to the leave, in which case the annual medical account contribution you elected would be reduced to reflect the period of no contributions.

  - You can elect to increase your contributions for the remainder of the year following the leave so that your annual contribution to the flexible spending medical account will equal the annual contribution in effect prior to the leave.

  For example, suppose you had elected a $1,200 flexible spending medical account (monthly contributions of $100) and were absent on leave for the months of April, May and June. When you return to work in July, you could continue to make contributions of $100 per month, in which case the maximum annual reimbursement from the flexible spending medical account would be $900 ($1,200 minus $300 in missed contributions). Alternatively, you could increase your monthly contribution to $150 for the remainder of the year and have a maximum annual reimbursement from the flexible spending medical account of $1,200 (three months of $100 contributions, three months of $0 contributions and six months of $150 contributions).

- Leaves of absence under this policy shall *not* constitute a break in the employee's length of continuous service; you will not lose any employment benefits you have accrued prior to taking leave.

- If you terminate your employment during your leave, the date of your qualifying event will be the day your employment ends with the Troy Area School District.

Please contact the Payroll Specialist regarding procedures and guidelines for the Family Medical Leave Act.

7. CONTRIBUTIONS FOR COVERAGE, SPECIAL RIGHTS FOR WOMEN, GENETIC NON-DISCRIMINATION ACT ("GINA"), NON ASSIGNMENT OF BENEFITS, CONTINUATION AND CONVERSION RIGHTS

Contributions for Coverage

Troy Area School District will pay the full cost of coverage for the following plans:

- Dental

You will pay a portion of the total premium cost of your coverage under the following plans:

- Medical (including prescription drugs) (pre-tax dollars)
  - Traditional Blue Cross / Blue Shield (no longer available for new enrollment)
  - BlueCare PPO

You will pay all of the cost of coverage under the following plans:

- Flexible Spending Account Plan (pre-tax dollars) (employees also pay an administrative charge each month with post-tax dollars)
- Vision (pre-tax dollars) (available to Support Staff personnel only who pay full premium)

A summary of the current structure of Participant pre-tax contribution requirements for the current Plan Year can be found in Attachment # 4.

With respect to benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, FMLA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, PPACA and WHRCRA.

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Special Rights for Women

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Genetic Information Nondiscrimination Act ("GINA")

GINA prohibits employer-sponsored group health plans and health insurers providing group insurance from:

- Increasing premium or contribution amounts based on genetic information;

- Requesting or requiring an individual or family member to undergo a genetic test; and
- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Genetic information means:

- The individual's genetic tests;
- The genetic tests of family members;
- The manifestation of a disease or disorder in family members; or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by the individual or family member.

Genetic information does not include information about the sex or age of any individual, it does include, with respect to a pregnant woman, an individual who is utilizing an assisted reproductive technology, or a family member, genetic information of any fetus carried by the pregnant woman or of any embryo legally held by the individual or family member.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

MHPAEA prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits.

Treatment limits include limits on the scope and duration of treatment.

The MHPAEA regulations set out a framework for assessing compliance with respect to financial requirements such as deductibles and coinsurance and quantitative treatment limits (e.g. day and visit limitations).

When the plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The Plan is prohibited from providing a more restrictive financial requirement or treatment limit than the predominant level that applies to all or substantially all medical/surgical benefits on any mental health or substance use disorder benefit within each of the above classifications.

Non-Assignment of Benefits

Except as may be required pursuant to a "National Medical Child Support Order" which provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefit.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends and if you have exhausted your rights under COBRA. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your benefit continuation or conversion rights, please contact the insurance company.

8. HOW THE PLAN IS ADMINISTERED

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Troy Area School District Payroll Specialist has been designated to act as the Plan Administrator for dental, vision, and flexible spending account plan benefits. Northern Tier Insurance Consortium serves as Plan Administrator for medical (including prescription drugs) coverage.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Duties of the Plan Administrator

1) To administer the Plan accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan.
2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3) Prescribe applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.
4) To decide disputes that may arise relative to a Plan participant's rights.
5) To prescribe procedures for filing a claim for benefits and to review claim denials.
6) To keep and maintain the Plan documents and all other records pertaining to the Plan.
7) To appoint a Claims Supervisor to pay self-insured claims.
8) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Plan Administrator Compensation

The Plan Administrator serves without compensation however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Power and Authority of the Plan Administrator

Troy Area School District has contracted with the following insurance company to provide fully-insured vision benefits through Blue Cross Blue Shield / Davis Vision.

The insurance company is responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plan, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

The Plan has benefits that are self-insured with administrative services provided by third party administrators. The Plan Administrator has delegated authority to the third party administrator and they are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Troy Area School District has contracted with the following third party administrators to provide the following benefits:

BCNEPA / First Priority Life	Medical (including prescription drugs)
Delta Dental	Dental
CBIZ	Flexible Spending Account Plan (including medical and dependent care spending accounts)

Questions

If you have questions regarding eligibility for, or the amount of, any benefit payable under the fully or self- insured component benefit plan, please contact the insurance company, third party administrator or the Plan Administrator.

9. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits

An Eligible Employee's benefits (and the benefits of his or her eligible spouses and dependents) will cease when the Employee's participation in the Plan terminates (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

Other Circumstances

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The group insurance contracts provide additional information.

10. AMENDMENT OR TERMINATION OF THE PLAN

Troy Area School District as the Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by Troy Area School District or any of its delegates. Troy Area School District reserves the right to modify the Plan, including but not limited to, an increase in employee contributions or reduction in benefits, or the suspension or termination of the entire Plan or any benefit offered under the Plan, at any time. Union employees covered by a collective bargaining agreement will be notified in advance of any changes. Should the Plan or any benefit offered under the Plan terminate, all eligible claims incurred prior to the termination date will be paid, subject to the procedures described in the section entitled "Claims Procedures". Any claims incurred after the date of termination of the Plan or any benefit offered under the Plan will not be considered for payment, except to the extent required by law.

The Business Manager signs administrative contracts for this Plan on behalf of Troy Area School District, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

11. NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Troy Area School District to the effect that you will be employed for any specific period of time.

12. CLAIM ADMINISTRATIVE SERVICES – FIRST PRIORITY LIFE

A. Payment of Benefits

The Employer shall assume all responsibility for funding of benefits under the Self-Funded Group Health Plan and First Priority Life assumes no obligation or risk associated with the funding of benefits. Further, First Priority Life provides administrative claims payment services only and does not assume any financial risk or obligation with respect to the payment of claims or claim determinations. Any dispute between a Provider, who is a member of a First Priority Life network or a Host Blue Network designated for use under the BlueCard program, and a Participant with respect to balance billing shall be submitted to First Priority Life for determination. The decision by First Priority Life shall be final.

The Covered Services set forth in the Benefit Schedule represent the health benefits payable under this Agreement. During the term of this Agreement, First Priority Life will administer claims for the Employer's health benefits program that are deemed Medically Necessary and appropriate by the Employer, subject to all of the terms and conditions set forth in this Agreement and the Benefit Schedule. The Cost of Services under this Agreement is described in Schedule 1 to this Agreement.

- First Priority Life will make payments directly to Providers, who are members of a First Priority Life network or a Host Blue Network furnishing Covered Services under the Agreement. However, First Priority Life reserves the right to make payments directly to the Participant.

  Copayment, Deductible and/or Coinsurance amounts, which are the responsibility of the Participant, must be paid, or arrangements to pay must be made, to the Provider, who is a member of a First Priority Life network or a Host Blue Network, by the Participant within sixty (60) days of the notification of First Priority Life's arranged payment to a Facility Provider and within sixty (60) days of the date in which First Priority Life finalizes services to a Professional Provider.

- If Covered Services are performed by a Provider who is not a member of a First Priority Life network or a Host Blue Network designated for use under the BlueCard program, First Priority Life will arrange to make payment to the Participant. Any difference between the Provider's charge and the First Priority Life arranged payment to the Participant shall be the personal responsibility of the Participant. First Priority Life shall not accept an assignment of benefits, unless otherwise specifically permitted under the health benefit program or required by law.

  In the event there are no Professional Providers of a needed specialty in a First Priority Life Network or a Host Blue Network, and First Priority Life determines through pre-certification that, as a result, a Participant is required to obtain care from such a Professional Provider, the Participant will not be subject to the financial penalty ordinarily applicable to the Covered Services of Professional Providers who are not members of a First Priority Life Network or a Host Blue Network.

B. Time Limit for Filing Claims

The timely filing of claims is the responsibility of any Provider who has signed an agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and/or is a member of the Host Blue Network designated for use under the BlueCard program and has been authorized by First Priority Life to provide Covered Services to a Participant. In such instances, the Participant shall have no filing responsibility for any such claim.

The timely filing of claims is the responsibility of any Participant who receives services from a Provider who has not signed a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and/or is not a member of the Host Blue Network designated for use under the BlueCard program and who has not been authorized by First Priority Life to provide Covered Services. No payment will be made for any claims unless written notice of such claim is given to First Priority Life within one (1) year of the date of service.

C. Issuance of Explanation of Benefits (EOB)

First Priority Life will arrange to have an EOB provided to each Participant for each claim submitted by or on behalf of a Participant. An EOB is not to be construed as evidence of a denial of benefits. An EOB is an explanation of how a claim for benefits has been processed to date and represents an initial determination by First Priority Life. By issuing EOB's, First Priority Life does not assume responsibility for providing an SPD.

D. Overpayment of Benefits

In the event First Priority Life overpays any Participant entitled to benefits under this Agreement, or pays benefits to any Participant or Provider who is not entitled to benefits under this Agreement, including payments on behalf of Participants when First Priority Life has received notification of termination from the Employer after a claim has been processed, First Priority Life shall take all reasonable steps to recover the overpayment, except that First Priority Life shall not be required to initiate court proceedings to recover an overpayment. In no event shall First Priority Life be liable to the Employer for any such overpayment paid under the provisions of this Agreement unless the overpayment resulted from fraud or an intentional or grossly negligent administrative error caused solely by First Priority Life. First Priority Life shall promptly notify the Employer if it is unsuccessful in recovering any overpayment and shall provide supporting claims documentation to the Employer in the event that Employer desires to institute collection proceedings.

E. Final Determination of Coverage

The Complaint and Grievance procedures specified in Exhibit C sets forth the manner by which a Participant may request a review of an initial determination of coverage by First Priority Life. Upon appeal of an adverse initial determination, First Priority Life agrees to make a final determination with regard to the denial of an initial claim or a denial of services whole or in part. First Priority Life and BCNEPA are fiduciaries with regard to eligibility for and benefit claims in the medical programs offered under the Plan.

F. Pre-Certification

First Priority Life shall also provide or arrange, as appropriate, for certification services to assess the Medical Necessity of specific proposed services for the purpose of offering a preliminary indication relating to coverage of such services under the health benefit program. First Priority Life, in the process of administering the Employer's benefits, may add, change or delete certain pre-certification services and processes utilized to assess Medical Necessity with prior notification to the Employer.

G. Cost Control

First Priority Life shall apply no less stringent standards of medical policy under this Agreement than it would provide and apply if it were "at risk" for the fees/premiums received from the Employer. In accordance with First Priority Life's Complaint and Grievance procedure set forth in Exhibit C, First Priority Life shall make an initial determination of benefits and the adverse Participant shall be entitled to request a review of that initial determination. The referenced Complaint and Grievance procedure is attached hereto and incorporated herein as Exhibit C.

H. Disease Management Programs

In exercising its authority under Article XIV, and to improve upon the health of Participants, First Priority Life shall make available to the Employer certain Disease Management Programs already developed and operational, or developed subsequent to the execution of this Agreement. These Disease Management Programs may include benefits that are not currently offered as Covered Services, or exceed a current benefit limitation, and the Employer will be responsible for any claims incurred by these Disease Management Programs. Upon request, First Priority Life will provide the Employer with a description of currently offered Disease Management Programs.

CLAIMS EXPENSE AND OTHER CHARGES TO THE SCHOOL DISTRICT

The school district shall pay and fund in full all Cost of Services on behalf of the school district plus any additional amounts set forth therein.

NOTICE OF DECISION OF A CLAIM

Claims under the Health Plan

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 90 days after the designated claims processor's receipt of the claim, unless special circumstances require an extension of up to 90 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 90-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination.

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

Review Procedures for Denied Claims

Review of Claims under the Health Plan

The following claims review procedures apply without regard to any conflicting procedures described in the attached booklet.

Appeal. If your claim for benefits is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim or no notification as to an extension of the determination period within 90 days after submission of the claim to the designated claims processor, the claim for benefits will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing a written request for review with the insurance company Claims Administrator.

You must file a written request for review of a denied claim within 60 days after you receive written notice of the denial of the claim, or within 60 days after the date such claim is deemed to be denied. In connection with an appeal, you shall be permitted to review pertinent documents with respect to your claim, as determined by the insurance company Claims Administrator. Additionally, you may submit to the insurance company Claims Administrator written issues and comments relating to your claim in connection with the insurance company Claims Administrator's review of your claim.

Review. The insurance company Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The insurance company Claims Administrator will render a decision regarding the claim within 60 days after the date the insurance company Claims Administrator receives your request for review, unless the insurance company Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the insurance company Claims Administrator will render a decision as soon as possible, but not later than 120 days after the insurance company Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the insurance company Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time.

The insurance company Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

Disposition on Review. You will receive written notification of the insurance company Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim; and
- Specific references to pertinent plan provisions on which the benefit determination is based.

If the decision on review is not furnished within the period specified above, the claim shall be deemed denied on review at the expiration of that period.

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

For purposes of determination of the amount of, and entitlement to benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance.

If your claim is denied, you may appeal to the insurance company.

SUBROGATION

A. Employer Responsibilities

Employer warrants that the SPD confers on the Employer rights of subrogation and third party recovery. Employer delegates or assigns these subrogation rights and third party recovery rights to First Priority Life as the Employer's agent for purposes of subrogation only.

B. First Priority Life's Subrogation Duties

First Priority Life shall undertake reasonable steps to identify claims in which the Employer has a subrogation interest and shall manage subrogation cases on behalf of the Employer. First Priority Life shall be subrogated, and succeed to the rights of a Participant for any and all recovery of Covered Services paid and reasonably expected to be paid against any person or organization except insurers or policies of health insurance issued to and in the name of Participant. First Priority Life shall provide the Participant's attorney with updated lien amounts, as requested, and shall work with the Participant's attorney to recover 100% of the Covered Services paid (unless such amount is compromised as set forth in Section C and D). First Priority Life shall credit the Employer with the amount received, minus, as applicable, First Priority Life's attorney's fees and its pro-rata share of the costs expended in the recovery of the subrogation interest.

In consideration for the advancement of benefits, First Priority Life is subrogated to all of the rights of the Participant against any party liable for the Participant's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Participant under First Priority Life. First Priority Life may assert this right independently of the Participant. This right includes, but is not limited to, the Participant's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Participant's rights under First Priority Life to bring an action to clarify his or her rights under First Priority Life. First Priority Life is not obligated in any way to pursue this right independently or on behalf of the Participant, but may choose to pursue its rights to reimbursement under First Priority Life, at its sole discretion.

C. Authority to Compromise Liens

In those instances where an Employer's subrogation lien should, in the opinion of First Priority Life, be compromised or abandoned, the Employer delegates to First Priority Life full authority to act on behalf of the Employer to compromise or abandon the lien. Any determination by First Priority Life with respect to subrogation liens shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review.

D. Participant's Duties

The Participant is obligated to cooperate with First Priority Life and its agents in order to protect First Priority Life's subrogation rights. Cooperation means providing First Priority Life or its agents with any relevant information

requested by them, signing and delivering such documents as First Priority Life or its agents reasonably request to secure First Priority Life's subrogation claim, and obtaining the consent of First Priority Life or its agents before releasing any party from liability for payment of medical expenses.

First Priority Life shall have the right to recover, against any source, which makes payments, or to be reimbursed by the covered Participant who receives such benefits, 100% of the amount of covered benefits paid. If the 100% reimbursement provided above exceeds the amount recovered by the covered Participant, less legal and attorney's fees incurred by the covered Participant in obtaining such recovery, the covered Participant shall reimburse First Priority Life the entire amount of such net recovery. The Participant shall take such action, furnish such information and assistance, and execute such papers as First Priority Life may require to facilitate enforcement of its rights and shall take no action prejudicing the rights and interests of First Priority Life. In those instances where the subrogation recovery efforts of the Participant's attorney should, in the opinion of First Priority Life, be compensated, the Employer delegates to First Priority Life full authority to act on behalf of the Employer to negotiate reasonable attorney fees, to be deducted from Participant's payment to First Priority Life, not to exceed forty percent (40%).

If the Participant enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the subrogation rights of First Priority Life under this section. In the event that the Participant fails to cooperate with this provision, including executing any documents required herein, First Priority Life may, in addition to remedies provided elsewhere in First Priority Life and/or under the law, set off from any future benefits otherwise payable under First Priority Life the value of benefits advanced under this section to the extent not recovered by First Priority Life.

First Priority Life's subrogation right takes first precedence and must be satisfied in full prior to any other claim of the Participant or his/her representative(s), regardless of whether the Participant is fully compensated for his/her damages. The costs of legal representation of First Priority Life in matters related to subrogation shall be borne solely by First Priority Life. The costs of legal representation of the Participant shall be borne solely by the Participant.

E. Prohibited by Law

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Claim Procedures for Self-Funded Flexible Spending Account Plan and Dental Benefits

Self-insured benefits listed in this Summary Plan Description and follow rules and guidelines listed in the Section titled Requesting Benefits and Filing Claims. Claim decisions for self-funded benefits are made by the Plan Administrator, Delta Dental and CBIZ.

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through Troy Area School District's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim.

To receive any benefit under this Plan, a covered Employee, his or her covered Dependents, and any representative designated by the covered Employee or a covered Dependent must follow the Plan's procedures for requesting benefits and filing claims. There are different types of claims. There are also different procedures that must be followed for each type of claim. Therefore, the covered Employee should read the procedures explained in this section of the document and ask questions about any procedures that he or she does not understand.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Insurance Laws

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the insurance company Claims Administrator has been rendered (or deemed rendered).

13. HIPAA PROVISIONS FOR HEALTH COMPONENT BENEFITS

This section shall be effective as of April 14, 2004. This section shall be interpreted in a manner that permits the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state laws regarding protection of Protected Health Information (PHI).

The health component benefits of the Plan will use and disclose protected health information (PHI), as defined in 45 CFR 164.501, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the health component benefits will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the health component benefit HIPAA Privacy Notice (as defined in 45 CFR 164.520) distributed to Participants.

The health component benefits of the Plan will disclose PHI to Troy Area School District only upon receipt of a certification from Troy Area School District that this Summary Plan Description has been amended to incorporate the provisions below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the health component benefits and Troy Area School District.

Troy Area School District's Obligations with Respect to PHI

With respect to PHI, Troy Area School District agrees to certain conditions. Troy Area School District agrees to:

- not use or disclose PHI other than as permitted or required by this Summary Plan Description or as required by law;
- ensure that any agents (including a subcontractor) to whom Troy Area School District provides PHI received from the Plan agree to the same restrictions and conditions that apply to Troy Area School District with respect to such PHI;
- not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Troy Area School District unless authorized by an individual;
- report to the Plan any PHI use or disclosures of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Troy Area School District will follow the privacy and security obligations required under the Health Information Technology for Economic and Clinical Health Act (HITECH) enacted February 17, 2009, including notification of a breach involving unsecured PHI within the required 60-day timeframe, securing PHI, and development of procedures for breach identification.

Access to PHI within Employer

Adequate separation will be maintained between the Plan and Troy Area School District. Only the individuals or classes of employees identified in the health component benefits HIPAA Privacy Notice distributed to Participants in accordance with HIPAA shall have access to PHI. The persons described in the health component benefits HIPAA Privacy Notice may use or disclose PHI only for Plan administration functions that Troy Area School District performs for the Plan. If the persons described herein or any other employees do not comply with the Summary Plan Description, Troy Area School District shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Troy Area School District shall cooperate with the Plan to correct and mitigate any such noncompliance.

Privacy Official

The Privacy Official shall be responsible for compliance with Troy Area School District and the health component benefits obligations under this section and HIPAA. Specific rules regarding the Privacy Official follow:

1. Appointment, Resignation and Removal of Privacy Official. Troy Area School District shall appoint one or more individuals to act as Privacy Official on matters regarding the health component benefits. The individual appointed as

Privacy Official may resign by giving 30 day notice in writing to Troy Area School District. Troy Area School District shall have the power to remove that individual for any or no reason.

2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and Troy Area School District such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with Troy Area School District, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

If you would like to place a request for alternate communications, or file a complaint regarding your privacy rights, you may contact us by writing to:

Troy Area School District
Privacy Officer – Traci Gilliland – Business Manager

It has always been the goal of Troy Area School District to ensure the protection and integrity of our members' personal and health information. Therefore, we will notify you of any potential situations where your information would be used for reasons other than payment and health plan operations.

HIPAA Security Standards

This section explains the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information under the security standards of HIPAA. These obligations are effective on April 21, 2005.

Where Electronic Protected Health Information (ePHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor will reasonably safeguard the ePHI as follows:

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan,
- The Plan Sponsor will ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures,
- The Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such ePHI, and The Plan Sponsor will report to the Plan any Security Incidents of which it becomes aware as described below:
- The Plan Sponsor will report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI, and
- The Plan Sponsor will report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

14. PARTICIPANT RIGHTS TO DOCUMENTS:

Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with any government agency.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator at the Business Office. Troy Area School District may make a reasonable charge for the copies.

- The people who operate your Plan, called "fiduciaries" of the plan, have a duty to operate the Plan prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under applicable law. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under the Plan document, and under applicable law, there are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a court of competent jurisdiction. If you have any questions about your Plan, you should contact the Plan Administrator.

15. SIGNATURE

IN WITNESS WHEREOF, we have executed this Plan Agreement the date and year first written above.

Employer/Plan Sponsor: _____
Troy Area School District

Date: _____

Attest: _____

Appendix 1

Outline of Coverage – BlueCare PPO - 1

Blue Care Preferred Provider Organization Program
Definitions
Care Coordination
Schedule of Covered Services
Description of Covered Services

Appendix 2 –
No longer available for new enrollment

Outline of Coverage – BlueCare Traditional
Definitions
Care Coordination

Prescription Drug Coverage

Exhibit C

Grievance and Complaint Procedures

BlueCare® PPO

Administrative Services Agreement

Part I— Outline of Coverage

Company Name: Northern Tier Insurance Consortium (NTIC) Troy Area School District

Group Numbers: 052227000, 052227001, 052227099

Company Code:	200210	Dependent/Student Age Limit:	26/26 end of month
Effective Date:	7/1/2012	New Born Children:	31 days
Renewal Date:	7/1/2013	Full-time student leave of absence:	Covered
Date - Part II Benefit Schedule:	7/1/2012	Domestic Partners:	Not Covered
Outline of Coverage Revision Date:		Credit (initial benefit period only)	
Grandfathered Status	No	Claims Appeal Fiduciary	BCNEPA
		Benefit Period	Calendar Year

	Participant Responsibility Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Deductible per person	None	$200	Per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non Preferred; Non-Preferred applies toward Preferred. *	
Deductible per family	None	$600	Maximum 3 separate deductibles per family, per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance	0%	20%	Allowable Charge'	
Coinsurance maximum per person	None	$2,000	Per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance maximum per family	None	$6,000	Maximum 3 separate coinsurance maximums per family, per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Lifetime Maximum	Unlimited	Unlimited		7/1/2011
Primary Care Office Visits	$10	20%	Unlimited Visits.	
Specialty Care Office Visits	$20	20%	Unlimited Visits	
Newborn Children	0%	20%	Newborn child claims are not subject to the deductibles	
Precertification Penalty (facility)	None	$500		
Preventive Care Services				
Childhood Immunizations	0%	20%	Pediatric Non-Preferred not subject to deductible.	7/1/2011
Routine gynecological exam and Pap Smears	0%	20%	Non-Preferred not subject to deductible. One routine exam per benefit period.	7/1/2011

	Participant Responsibility Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Routine physical exams	0%	20%	Routine exams are preventive medical evaluations and management exams.	7/1/2011
Mammography screenings/ diagnostic	0%	20%	Non-Preferred not subject to deductible.	7/1/2011
Nutritional Therapy	0%	20%	6 visits per member per benefit period.	7/1/2011
Routine colorectal cancer and prostate cancer screening	0%	20%	Non-Preferred not subject to deductible	7/1/2011
Emergency Services Ambulance Emergency Transport	0%	0%	Non-Preferred Emergency Transports only are not subject to deductible. Non-preferred participant maybe liable for charges that exceed the allowable charge.'	
Ambulance - Non-Emergency Transport	0%	20%	Non-preferred participant maybe liable for charges that exceed the allowable charge.	
Emergency room visit	$50	$50	Non-Preferred not subject to deductible, copay waived if admitted to hospital.	
Inpatient Services				
Inpatient Copay per admission	Not Applicable	Not Applicable		
Inpatient hospital services	0%	20%	Unlimited days per benefit period.	
Inpatient Rehabilitation	0%	20%	45 days per benefit period.	
Skilled nursing care	0%	20%	60 days per benefit period.	
Transplants	0%	20%		
Outpatient Services				
High-tech imaging (MRI, MRA, CT, PET Scans, nuclear cardiology	$75 copay per test	20%		
Diagnostic testing (lab tests, x-ray, etc.)	0%	20%		
Maternity care (outpatient Physician visits)	$20	20%	Routine neonatal circumcision covered. Preferred copay for initial office visit, then covered in full for 2nd and subsequent visits	
Radiation, dialysis or chemotherapy	0%	20%		
Physical Therapy	$20	20%	20 visits per Benefit Period.	
Speech Therapy	$20	20%	12 visits per benefit period.	
Occupational Therapy	$20	20%	12 visits per benefit period.	
Pulmonary Rehabilitation Therapy	0%	20%	18 visits per benefit period.	
Cardiac Rehabilitation	0%	20%	36 visits per benefit period.	
Respiratory therapy	0%	20%	18 visits per benefit period.	
Surgery	0%	20%		
Other Services				
Autism Spectrum Disorders	0%	20%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21. Coverage is subject to any applicable copays, coinsurance, and/or deductible. $36,000 limit per member per benefit period.	

	Participant Responsibility Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Chiropractic manipulative benefits	$20	20%	12 treatments per benefit period, ages 13 and up. All services billed by a chiropractor are applied to the chiropractic benefit. If no Coinsurance Specialty Copay applies per provider per visit.	
Durable medical equipment, Prosthetics, & Orthotics	0%	20%	unlimited maximum	7/1/2011
Ostomy Supplies	50%	Not Covered	Ostomy appliances and supplies specifically relating to an ostomy. Limited to collection devices, irrigation equipment and supplies, skin barriers and skin protectors; and urinary catheters, both re-usable or disposable, whether or not used in conjunction with an ostomy. Covered up to $1,000 maximum per participant per benefit period. Amounts are applied to coinsurance maximum but will always pay at coinsurance amount.	
Home health services	$20	20%	Specialty Copay applies per day per provider.	
Home Infusion (nurse visit)	$20	20%	Specialty Copay applies to nurse visit only.	
Hospice care	0%	20%	180-day lifetime maximum.	
Private Duty Nursing	Not covered	Not covered		
Oral Surgery	0%	20%		
Morbid Obesity	0%	20%	Surgery and medically necessary panniculectomies for participants 18 years or older who has no prior medical history or bariatric surgery; 1 morbid obesity procedure and 1 panniculectomy covered per lifetime. $2,000 copay per morbid obesity procedure; $1,000 copay per procedure for medically necessary panniculectomies.	
Bony impacted wisdom teeth	50%	Not covered	In office setting only. Coinsurance applies even after coinsurance maximum is met.	
Prescription Glasses / Contacts following Cataract Surgery	0%	20%	Post-cataract prescription glasses or contact lenses are covered, limited to a lifetime maximum of $350 per member.	
Infertility	0%	20%	Diagnostic services leading up to the diagnosis of infertility. Applicable copayment for office visits.	
Invitro Fertilization	Not Covered	Not Covered		
Artificial Insemination	0%	20%	3 attempts per lifetime.	
Non-elective abortion	0%	20%		
Voluntary Sterilization	0%	20%	Reversals not covered.	

	Participant Responsibility Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Prescription Drugs				
Deductible per person	None	Not Covered		
Deductible per family	None	Not Covered		
Maximum per person	None	Not Covered		
Maximum per family	None	Not Covered		
Yearly maximum	None	Not Covered		
Lifetime maximum	None	Not Covered		
Formulary	Multi-tier	Not Covered		
Retail	Covered	Not Covered	30-day supply.	
Tier 0	$0	Not Covered		
Tier 1	$10	Not Covered		
Tier 2	$10	Not Covered		
Tier 3	$25	Not Covered		
Specialty Drugs (Tier 5)	Not Covered	Not Covered	Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of $3,000 per participant per Benefit Period.	
Mail Order	Covered	Not Covered	Up to a 90-day supply.	
Tier 0	$0	Not Covered		
Tier 1	$20	Not Covered		
Tier 2	$20	Not Covered		
Tier 3	$75	Not Covered		
Contraceptives	Covered	Not Covered	Excluding Devices	
Exclusive Home Delivery	No	Not Covered	One original fill plus one refill available at the retail pharmacy.	
Select Home Delivery	Yes	Not Covered	Participants are required to make a choice about their maintenance prescription drugs. Participants will have 2 fills at the retail pharmacy and then be required to contact Express Scripts with a decision on their third fill to continue through the retail pharmacy or switch to a mail order program.	
Mandatory Generic	Yes	Not Covered	Participant is responsible for the difference in cost between the brand name and generic drug if the participant or physician selects a brand name drug when there is a generic available.	
Quantity Limits	Yes	Not Covered	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Yes	Not Covered	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	

	Participant Responsibility Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Metabolic Supplement	Yes	Not Covered	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Yes	Not Covered	The program requires the use of a first step drug(s) before use of a 2nd or 3rd step drug.	
Prior Authorization	Yes	Not Covered	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Vaccine Program	Yes	Not Covered	Vaccines are provided and administered by pharmacists contracted to administer vaccines.	
Weight Loss Drugs	Not Covered	Not Covered		
Other				
Mental Health				
Inpatient services	0%	20%	Unlimited days	
Outpatient services	0%	20%	Unlimited visits.	
Substance Abuse				
Outpatient services	0%	20%	Unlimited visits.	
Detoxification	0%	20%	Unlimited visits.	
Inpatient Non-hospital residential substance abuse treatment	0%	20%	Unlimited days.	
Mental Health/ Substance Abuse				
Outpatient emergency room visit	$50	$50	Non-Preferred not subject to deductible, copay waived if admitted to hospital.	
Ambulance services, emergency transport	0%	0%	Not subject to deductible. Non-preferred participant maybe liable for charges that exceed the allowable charge.'	
Ambulance services, non-emergency transport	0%	20%		

Exclusions Please see attached

Part II Administrative Services Agreement Benefit Schedule is the Covered Service descriptions and will apply as stated, unless otherwise indicated on Part I Outline of Coverage.

' The allowable charge is established by a provider agreement or is the billed amount, whichever is less, and will be accepted by the preferred provider as payment in full for covered services less any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums. For a non-preferred provider, the allowable charge is the same amount First Priority Life would pay to a preferred provider. The Participant is liable for charges that exceed the allowable charge in addition to any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums.

[2] When Aggregate Deductible is applicable, no individual will pay more than the individual deductible or coinsurance maximum amount. The family deductible or coinsurance maximum can be met by any combination of family members.

[3] When Aggregate Coinsurance Maximum is applicable, One family member must meet the individual coinsurance maximum. Any combination of the remaining family members can contribute to the family coinsurance maximum.

* Coverage described in this column applies when services are performed by Preferred Provider, or are otherwise in accordance with network rules. Coinsurances are still the responsibility of the Participant.

** Coverage described in this column applies when services are not performed by Preferred Provider, or are otherwise not in accordance with network rules. The Participant remains responsible for any applicable copayments, deductibles, and/or coinsurance.

The Plan will follow First Priority Life precertification guidelines. Unless otherwise indicated, the Plan will follow First Priority Life Medical Policy.

PPO
Standard Exclusions

This amends the Administrative Service Agreement Preferred Provider Organization as follows:

EXCLUSION is amended by adding the Standard Exclusions as indicated below:

A. Except as may be specifically provided in the Description of Covered Services, the following are not covered under the Plan:

1. Services which are not Medically Necessary, except those that are provided within the Policy for preventive services or those mandated by law.

2. Any service in connection with or required by a procedure not set forth in the foregoing Description of Covered Services Section, except as necessitated by subsequent complications.

3. Services in excess of any Benefit Maximum as stated.

4. Charges for services or supplies incurred prior to the Participant's Effective Date.

5. Except as provided by the Plan, charges for services or supplies incurred after the date of termination of the Participant's coverage.

6. Charges, which exceed the Allowable Charge.

7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.

8. Services which First Priority Life initially determines are Experimental or Investigative; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative.

9. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation; or losses sustained or expenses incurred as a result of act of war whether declared or undeclared.

10. Treatment or services received as a result of the Participant's participation in a riot or insurrection.

11. Services as a result of injuries sustained during the Participant's commission of or attempt to commit a felony.

12. Services for which an Participant would have no legal obligation to pay.

13. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from Surgery.

14. The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy; otoplasty; rhytidectomy; blepharoplasty; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following a Mastectomy; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.

15. Treatment of temporomandibular joint (TMJ) or myofascial (MPD) pain dysfunction or craniomandibular (CMD) pain syndrome, including surgical and non-surgical exam, invasive and non-invasive procedures and tests, and all related medical and surgical services. Examples of non-Covered Services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.

16. With respect to the extraction of partially or totally bony impacted wisdom teeth:
    a. Hospital and Ambulatory Surgical Facility services are not covered, except if authorized by a Medical Director of First Priority Life as set forth in Section DB — Description of Covered Services, Subsection D, Surgery, Paragraph 3.
    b. General anesthesia charges are not covered, except as indicated in Section DB — Description of Covered Services, Subsection D, Surgery, Paragraph 3
    c. With respect to all other dental procedures and oral Surgery, the following are excluded:
        i. Removal of natural teeth, except when removal of teeth is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations.
        ii. All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injuries to the jaws, natural teeth, mouth or face. Chewing or biting shall not be considered an accidental injury.
        iii. Dental appliances, including, but not limited to dentures and bridges, except for the primary restoration following facial/dental trauma or when an integral part of a cleft palate repair.
        iv. Periodontics, endodontics, and orthognathic Surgery.
        v. Dental implants
        vi. Treatment of diseases of the teeth or gums, including, but not limited to treatment of dental cavities.
        vii. Periodontics, endodontics, and orthognathic Surgery.
        viii. Orthodontics, except orthodontic treatment related to cleft palate repair as described in Section DB — Description of Covered Services, Subsection D, Surgery, Paragraph 1.
        ix. Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.
        x. Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures unless such procedures were for the treatment of accidental bodily injury.

17. Charges to the extent payment has been made under Medicare when Medicare is the primary carrier or by any other federal, state, or local government program, except Medicaid.

18. Charges to the extent payment has been made under a state or Federal workers' compensation, employer's liability or occupational disease law, or local government program.

19. 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 or any applicable federal or state law. This exclusion applies regardless of whether the Participant claims the benefit compensation.

20. Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD under the Agreement and for Participants age twenty-one (21) and over.

21. Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in Section DB — Description of Covered Services.
    a. Treatment of Autism Spectrum Disorder through the use of Chelation Therapy.
    b. Any services listed in an Individual Education Plan (IEP) are not covered.
    c. Services for treatment of anti-social personality, conduct disorders and paraphilias.

22. Substance Abuse services utilizing methadone or methadone-like equivalents.

23. Biofeedback/neurofeedback.

24. Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.

25. Routine and cosmetic foot care, except for care provided as a result of diabetes.

26. The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes or as certified Medically Necessary for children due to the growth process.

27. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.

28. Custodial care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.

29. Physical, psychiatric or psychological examinations, testing, reports, or treatments, when such services are: (a.) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (b.) relating to judicial or administrative proceedings or orders; (c.) conducted for purposes of medical research; or (d.) to obtain or maintain a license of any type.

30. Services and associated expenses related to the non-surgical, medical treatment of obesity, including but not limited to, dietary supplements or programs for weight reduction.

31. Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except those drugs that are mandated to be covered by law and/or that provide at least thirty-five (35) percent of daily caloric requirements given enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take nutrition by mouth, or in conditions of gastrointestinal tract impairment, parenterally through an intravenous catheter.

32. Infant formulas including those prescribed for reasons of fat malabsorption, lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic Formulas, except those that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

33. The purchase of organs, which are sold rather than donated to transplant recipients, and charges for organ donor searches are also excluded from coverage.

34. Long-Term Residential Care.

35. Outpatient cognitive rehabilitation services have been determined by First Priority Life not to be Medically Necessary and appropriate for the treatment of brain injury and are not covered by this Policy.

36. Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.

37. Pulmonary Rehabilitative Therapy on an Inpatient basis.

38. Reversal of voluntary sterilization.

39. Transsexual Surgery and treatment and services in support of transsexual Surgery, except for treatment resulting from a complication of such transsexual Surgery.

40. Charges in connection with penile implants.

41. Abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.

42. Separate charges by interns, residents, and other health care professionals who do not have a Provider Agreement with First Priority Life, who are directly, or indirectly employed by a Hospital or Facility Other Provider which makes their services available.

43. Corneal Surgery to change the shape of the cornea to correct vision problems, except for accidental injury or Medically Necessary conditions resulting from corneal Surgery.

44. Routine eye examinations; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.

45. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to allergen filtration systems, including allergy products.

46. Charges for telephone calls or telephone consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.

47. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.

48. Assisted fertilization techniques such as, but not limited to, In Vitro Fertilization (IVF), of any kind including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment, embryo acquisition, storage and transport, human chorionotropin, urofollitropin, menatropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.

49. Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise determined by First Priority Life to be nonstandard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, or prosthetic socks, except when administered by a home health agency as part of the home health benefit or as provided in Section DB — Description of Covered Services, Subsection X, Diabetes Education/Equipment/Supplies or Subsection FF, Ostomy Supplies; (d) exercise equipment; (e) self-help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or price of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in Section DB — Description of Covered Services, Subsection D, Surgery; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) pro-glide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; and (v) modification or customization of any Durable Medical Equipment.

50. Examinations for the prescription, fitting or adjustment of hearing aids.

51. Travel or transportation expenses, even though prescribed by a physician, except ambulance service as outlined I Section DB - Description of Covered Services, Ambulance Services.

52. Services performed by a Provider with the same legal residence as a Participant or who is a family member, including but not limited to: spouse, brother, sister, parent or child.

53. Services of Immediate Family or persons of the Participant's Household.

54. Alternative and complementary medicine, except as provided in the Care Coordination, Case Management.

55. Adult circumcision in the absence of disease.

56. Charges for a private room when a Semi-Private Room is available.

57. Services, which are not prescribed, performed or directed by a Provider licensed to do so.

58. Educational classes, support groups and disease management programs unless sponsored or provided by First Priority Life or required for diabetes education services and those that are mandated to be covered as required by law.

59. Unattended Services.

60. Take-home drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider; injectable or implantable contraceptive drugs and devices that are not self-administrable (except when used for an approved medical condition other than contraception) and fertility drugs regardless of use; drugs in certain drug classes specifically designated by First Priority Life as Specialty Drugs including, but not limited to: self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives unless provided in connection with covered transplants, monoclonal antibodies, and other biotech drugs; except those drugs administered by a Preferred Professional Provider that are not self-administrable and/or that are provided incident to a Covered Service; those drugs that are mandated to be covered by law; and/or which are covered under the Prescription Drug Coverage, when coverage is provided for Prescription Drugs. (The Outline of Coverage specifies whether Prescription Drug coverage applies.)

61. Copayments, Deductibles, Coinsurance or penalties applied under the Agreement.

BLUECARE PREFERRED PROVIDER ORGANIZATION PROGRAM

This Benefit Schedule is a summary of the Covered Services and main features of the BlueCare Preferred Provider Organization (PPO) benefit program. Please reference the Summary Plan Description carefully to determine which health care services are covered.

The BlueCare PPO health benefits program includes coverage for Facility, Physician and Other Professional Provider services.

Some Covered Services are subject to Pre-certification before qualifying for coverage, and some services require a Copayment, Coinsurance, or satisfaction of an annual Deductible. The attached Part II Benefit Schedule and Part I Outline of Coverage describe in detail your Covered Services and limitations and exclusions as the Group Health Plan indicated.

DEFINITIONS

The following words and phrases when used in the agreement shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. ADJUNCTIVE PROCEDURES – Physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization performed by an individual holding the appropriate licensure and certification.

2. ALCOHOL AND/OR DRUG ABUSE – Any use of alcohol or other drugs 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. For the purposes of the agreement, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).

3. ALLOWABLE CHARGE – **ALLOWABLE CHARGE** – In the case of a Preferred Professional Provider, the Allowable Charge is established by a Provider Agreement or is the billed amount, whichever is less, and will be accepted by the Preferred Professional Provider as payment in full for Covered Services. The Participant will be liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Professional Provider, the Allowable Charge is based on the payment/rate that the Host Blue passes on to First Priority Life, or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[1], the Participant will be liable for any Non-Preferred Participating Professional Provider Deductibles or Coinsurance, or Copayments. The Participant will also be responsible for amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Professional Provider, the Allowable Charge is the same amount First Priority Life would pay to a Preferred Provider, or is the billed amount, whichever is less, with the exception of Outpatient Emergency Services[1]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non-Preferred Professional Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

[1] In the event that the Participant received Outpatient Emergency Services by a Non-Preferred Participating/Nonpreferred Provider, First Priority Life will provide coverage at the Preferred Provider level and the Participant's Out-OfPocket expenses will be no greater than the amount that would have been incurred if a Preferred Provider had been used.

In the case of a Preferred Facility Provider, the Allowable Charge is established by a Provider Agreement pertaining to payment for Covered Services and will be accepted by the Preferred Facility Provider as payment in full for Covered Services. The Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Facility Provider, the Allowable Charge is the payment/rate that the Host Blue passes on to First Priority Life or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[1], the Participant is liable for any Non-Preferred Participating Facility Provider Deductibles, Coinsurance, or Copayments. The Participant is also responsible for amounts exceeding any Benefit Maximum, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Facility Provider, the Allowable Charge is the same amount First Priority Life would pay for services received by a Preferred Facility Provider, or the billed amount, whichever less, with the exception of Outpatient Emergency Services[1]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non- Preferred Facility Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

Participants may contact BlueCare Service Representatives toll-free at 1-888-338-2211 weekdays during normal business hours for a determination of Covered Services. Hearing impaired persons can call (TTY) 1- 866-280-0486. Participants may also write to:

First Priority Life
19 North Main Street Wilkes-
Barre, PA 18711

4. ALTERNATIVE TREATMENT PLAN – A voluntary program whereby the Participant is offered cost-effective treatment alternatives in lieu of the stated Covered Services in the Agreement, without compromising the quality of care. First Priority Life's Care Management Department, in cooperation with the Physician, organizes and coordinates care through multi-disciplinary resources.

5. AMBULATORY SURGICAL FACILITY – A Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, by the Accreditation Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to First Priority Life which:

a. has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;

b. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the facility;

c. does not provide Inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

6. APPLIED BEHAVIORAL ANALYSIS – 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.

7. AUTISM SERVICE PROVIDER – A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in Pennsylvania. Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth's medical assistance program on or before the effective date of this section.

8. AUTISM SPECTRUM DISORDER (ASD) – 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 disorders not otherwise specified.

9. BEHAVIOR SPECIALIST – An individual who designs, implements or evaluates a behavior modification intervention component of a Treatment Plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

10. BENEFIT PERIOD – A Calendar Year or a Benefit Year. ***(Refer to the Outline of Coverage for the period selected by the Plan.)***

11. BENEFIT YEAR – A period of twelve (12) consecutive months beginning with the Effective Date of the Plan during which charges for Covered Services must be incurred in order to be eligible for payment by First Priority Life. A charge shall be considered incurred on the date the service or supply was provided to a Participant. ***(Refer to the Outline of Coverage for the period selected by the Plan.)***

12. BEHAVIORAL HEALTH ACUTE CARE – Health care delivered to a Participant, experiencing an acute illness or trauma, consisting of high level skilled psychiatric or Substance Abuse services within a free-standing psychiatric hospital, a psychiatric unit of a general hospital or a detoxification unit within a Hospital setting.

13. BUSINESS DAY – A day that First Priority Life is open for business.

14. CALENDAR YEAR – A one-year period which begins on January 1 and ends on December 31**.** ***(Refer to the Outline of Coverage for the period selected by the Plan.)***

15. CHEMOTHERAPY – The treatment of disease by chemical or biological therapeutic agents.

16. CHIROPRACTIC MANIPULATIVE TREATMENT (CMT) – A form of manual treatment to influence joint and neurophysiological function or the use of Adjunctive Procedures in treating misaligned and displaced vertebrae or articulation and related conditions of the nervous system provided by an individual holding the appropriate licensure and/or certification.

17. COINSURANCE – A specific percentage amount of the Allowable Charge, set forth in ***the Outline of Coverage***, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

18. COINSURANCE MAXIMUM – A specified dollar amount of Coinsurance incurred by a Participant, as set forth in ***the Outline of Coverage***, for Covered Services in a Benefit Period. ***(Refer to the Outline of Coverage for the period selected by the Agreement.)*** The Coinsurance Maximum does not include removal of bony impacted wisdom teeth when performed by a Preferred Provider, penalties for failure to obtain Pre-Certification, Deductibles, Copayments, amounts in excess of the Allowable Charge, charges for non-Covered Services and charges after Covered Services have been exhausted, and any Deductible or Copayment amounts payable by the Insured for Covered Services under any rider attached to the Agreement.

19. COMMUNITY BEHAVIORAL HEALTHCARE NETWORK OF PENNSYLVANIA (CBHNP) – First Priority Life's dedicated unit that provides eligibility verification, triage, referral and utilization management for mental health- chemical recovery (behavioral health) services.

20. COPAYMENT – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth in the Agreement and in ***the Outline of Coverage***.

21. COSMETIC PROCEDURE – A medical or surgical procedure which is primarily performed to improve the appearance of any portion of the body.

22. COVERED SERVICES – All Medically Necessary Provider services and supplies which are administered by First Priority Life under the terms of this Agreement.

23. CUSTODIAL CARE – Services to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of skilled, trained medical or paramedical personnel. In determining whether a

person is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential, or place of service.

24. DEDUCTIBLE – A specified amount of Covered Services, as set forth in ***the Outline of Coverage***, expressed in dollars that must be incurred by a Participant before First Priority Life will assume any liability for all or part of the remaining Covered Medical Expenses.

25. DEPENDENT – The spouse of a Participant; or the Participant's or the Participant's spouse's child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.

26. DETOXIFICATION – The process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol, drug or other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum**.**

27. DIAGNOSTIC ASSESSMENT OF ASD – Medically necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician Assistant, licensed Psychologist or Certified Registered Nurse Practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

28. DIAGNOSTIC SERVICES – The following procedures ordered by a Physician because of specific symptoms and signs to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in Description of Covered Services and include, but are not limited to:

a. diagnostic imaging;

b. diagnostic pathology, consisting of laboratory and pathology tests;

c. diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life; and

d. allergy testing consisting of percutaneous, intracutaneous and patch tests.

29. DURABLE MEDICAL EQUIPMENT – Equipment which:

a. can withstand repeated use; and

b. is primarily and customarily used to serve a medical purpose; and

c. generally is not useful to a person in the absence of an illness or injury; and

d. is appropriate for use in the home.

30. ELIGIBLE PERSON – A person entitled to be a Participant as specified in the Schedule of Eligibility.

31. EMERGENCY MEDICAL CONDITION – means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867 (e) (1)(A) of the Social Security Act.

32. EMERGENCY SERVICE – means (i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

33. EMPLOYEE – An individual, who performs services in the regular course of the business of the Plan, is considered full time, works a minimum of thirty (30) hours per week, receives wages or salary in accordance with the Pennsylvania minimum wage laws and is reported on federal and/or state payroll tax. The term employee of a church or convention or association of churches will include a duly ordained, commissioned, or licensed minister of a

church in the exercise of his or her ministry regardless of the source of his or her compensation.

34. EXPERIMENTAL OR INVESTIGATIVE – The use of any treatment, procedure, facility, equipment, drug, device or supply that is determined to be not supported by evidence-based medicine and therefore:

a. Not accepted by the general medical community as standard medical treatment of the condition being treated or does not have definitive outcome studies in peer-reviewed medical literature demonstrating safety and efficacy for treating or diagnosing the condition or illness for which its use is proposed and/or lacks studies comparing outcomes to existing approved modalities of therapy or diagnosis; or

b. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information for the Health Care Professional as appropriate for the proposed use at the time services were rendered; or

c. Subject to review and approval by any institutional review board for the proposed use; or

d. The subject of an ongoing clinical trial that meets the definition of a phase I or II clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

35. FACILITY OTHER PROVIDER – An institution or entity, other than a Hospital, that is licensed, where required, to render Covered Services.

36. FACILITY PROVIDER – A Hospital or Facility Other Provider, licensed where required, to render Covered Services.

37. FAMILY COVERAGE – Coverage for the Participant and one or more of the Participant's Dependents.

38. FIRST PRIORITY LIFE PPO NETWORK – The BlueCare PPO Network or any other Preferred Provider Organization ("PPO") Network sponsored by First Priority Life.

39. FREESTANDING DIALYSIS FACILITY – A Facility Other Provider, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home-care basis.

40. FREESTANDING OUTPATIENT FACILITY – A Facility Other Provider, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.

41. FULL-TIME STUDENT – An individual who is enrolled in a recognized college or university carrying a minimum of twelve (12) undergraduate credits or nine (9) graduate credits per semester, or enrolled full-time in a trade or secondary school.

42. HIPAA – The federal Health Insurance Portability and Accountability Act of 1996.

43. HOMEBOUND – A Participant will be considered homebound if he/she has a condition due to an illness or injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated. The condition of these Participants should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.

44. HOME HEALTH CARE AGENCY – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license:

a. provides skilled Outpatient services on a visiting basis in the Participant's home; and

b. is responsible for supervising the delivery of such services under a plan authorized by the Physician

45. HOME INFUSION THERAPY – The preparation and administration of parenteral and enteral nutrition and/or intravenous solutions and drugs, which are provided in the home or infusion center setting.

46. HOME INFUSION THERAPY AGENCY – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life; is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license; provides Home Infusion Therapy services in the Participant's home or an infusion center; and is responsible for supervising the delivery of such services under a plan authorized by the Physician.

47. HOSPICE – A Facility Other Provider, which is primarily engaged in providing supportive care to terminally ill individuals.

48. HOSPICE CARE – A health care program which provides an integrated set of services, primarily in the patient's home, designed to provide supportive care intended to promote comfort to terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the Participant's Physician.

49. HOSPITAL – A Provider that is a short-term, acute care or Rehabilitation Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Hospital Association, the Pennsylvania Department of Health, or a similar accrediting agency acceptable to First Priority Life, or a Provider that is a state-owned Psychiatric Hospital, and which:

a. is a duly licensed institution;

b. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;

c. has organized departments of medicine and/or major Surgery;

d. provides 24-hour nursing service by or under the supervision of Registered Nurses; and

e. is not, other than incidentally, a:

- Skilled Nursing Facility
- nursing home
- Custodial Care home
- health resort
- spa or sanitarium
- place for rest
- place for the aged
- place for the provision of Hospice Care, or - personal care home.

50. HOST PLAN – The on-site Blue Cross/ Blue Shield Plan, which services the geographic area outside the Service Area where the Covered Services are provided.

51. IDENTIFICATION CARD/CARD CARRIER – The currently effective card/card carrier issued to the Participant and Dependents by First Priority Life.

52. IMMEDIATE FAMILY – The Participant's spouse, child, stepchild, parent, brother, sister, mother-in-law, father- in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

53. INDIVIDUAL EDUCATION PLAN (IEP) – A plan for school-based services.

54. INPATIENT – A Participant who is treated as a registered bed patient in a Hospital or Facility Other Provider, who is expected to stay overnight and for whom a room and board charge is made.

55. INPATIENT MENTAL HEALTH HOSPITAL – A short-term acute care Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association, or a similar accrediting agency acceptable by First Priority Life and which provides services that are necessary for short-term evaluation, diagnosis, and treatment (or crisis intervention) of Serious Mental Illness.

56. INPATIENT NON-HOSPITAL RESIDENTIAL CARE – The provision of medical, nursing, counseling, or therapeutic services to patients suffering from Alcohol and/or Drug Abuse or dependency in a residential environment,

according to individualized treatment plans.

57. INPATIENT NON-HOSPITAL RESIDENTIAL FACILITY – A Facility Other Provider licensed by the Pennsylvania Department of Health to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care. (This is not a half-way house or group home.)

58. LICENSED PRACTICAL NURSE (LPN) – A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

59. LONG-TERM RESIDENTIAL CARE – The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day to day activities and responsibilities) to patients suffering from Alcohol and/or Drug Abuse or dependency. This care is provided in a long-term residential environment known as a Transitional Living Facility, on an individual, group, and/or family basis, with a program duration greater than sixty (60) days. Long-Term Residential Care is not Inpatient Non-Hospital Residential Care.

60. MASTECTOMY – Removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

61. MAXIMUM – The greatest Covered Service amount payable by First Priority Life. This could be expressed in dollars, number of days, or number of services for a specified period of time.

a. BENEFIT MAXIMUM– The greatest Covered Service amount payable by First Priority Life for a specific Covered Service.

b. LIFETIME BENEFIT MAXIMUM – The greatest Covered Service amount payable by First Priority Life in the Participant's lifetime set forth in ***the Outline of Coverage***.

62. MEDICAL CARE/MEDICAL SERVICES – Services rendered by a Professional Provider intended to prevent illness (routine preventive care) and/or restore health (treatment of an illness or injury).

63. MEDICALLY NECESSARY or MEDICAL NECESSITY – Services or supplies rendered by a Provider that First Priority Life determines are:

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

b. provided for the diagnosis, or the direct care and treatment of the Participant's condition, illness, disease or injury;

c. in accordance with current standards of medical practice;

d. not primarily for the convenience of the Participant, or the Participant's Provider; and

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

64. MEDICARE – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

65. MENTAL OR NERVOUS DISORDER – Mental, nervous, or emotional disorder means a neurosis, psychoneurosis, psychopathy, or psychosis.

66. METABOLIC FORMULAS – Special nutritional formulas administered under the direction of a Physician, which are necessary to sustain life for a genetic metabolic disorder.

67. MORBID OBESITY – The term refers to patients who have a body mass index (BMI) of 40 or greater.

68. NUTRITIONAL THERAPY – Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a licensed health care professional to help a person make and maintain healthy dietary changes.

69. ORTHOSIS – A rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

70. OSTOMY – An artificial stoma or opening into the urinary tract, gastrointestinal canal or the trachea.

71. OSTOMY SUPPLIES – Generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advice of a healthcare Provider.

72. OUT-OF-POCKET – A dollar amount paid by the Participant which includes Deductible, Coinsurance, and Copayment amounts. It does not include penalties for failure to obtain Pre-Certification, premiums, amounts in excess of the Allowable Charge, charges for non-Covered Services, and charges after Covered Services have been exhausted.

73. OUTPATIENT – A Participant who receives services or supplies while not an Inpatient.

74. PARTIAL HOSPITALIZATION PSYCHIATRIC CARE SERVICES – The provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.

75. PARTIAL HOSPITALIZATION SUBSTANCE ABUSE SERVICES – The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-hospital facility licensed by the Department of Health or provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient care.

76. PHARMACY CARE – 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.

77. PHYSICIAN – A person, who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and prescribe and administer drugs.

78. PRE-CERTIFICATION – First Priority Life may add or delete services, which require Pre-Certification, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan at the address on the records of First Priority Life at least thirty (30) days in advance of such change.

79. PRIVATE DUTY NURSING – Total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.

80. PROFESSIONAL PROVIDER – An individual or practitioner, who is licensed/certified to render Covered Services, Professional Providers include, but are not limited to:

- Certified Addiction Counselor
- Chiropractor
- Clinical Psychologist
- Clinical Nurse Specialist
- Dentist
- Licensed Dietitian
- Licensed Practical Nurse
- Nurse Midwife
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physical Therapist
- Physician
- Physician Assistant
- Podiatrist
- Registered Nurse
- Social Worker
- Speech Therapist

81. PROSTHESIS – An artificial body part, which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.

82. PROVIDER – A Facility Provider, Professional Provider, Pharmacy Provider, or Supplier licensed, where required, and performing services within the scope of such license.

- **PREFERRED PROVIDER** – A Provider who has signed a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and/or has signed a Provider Agreement with and is a member of the Host Blue PPO Network designated for use under the BlueCard program.

- **PREFERRED FACILITY PROVIDER** – A Facility Provider that has a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider program or through a Provider that has signed a Provider Agreement with and has been designated by a Host Blue as a member of its BlueCard PPO Network under the BlueCard program. When a Provider of the First Priority Life PPO Network, the Highmark Blue Shield PPO Network, or the Host Blue PPO Network is used by Participants of the Agreement, coverage will be provided at the Preferred Provider level.

- **PREFERRED PROFESSIONAL PROVIDER** – A Professional Provider who has an agreement with First Priority Life and/or Highmark Blue Shield, as applicable, pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider Program or through a Professional Provider who has signed a Provider Agreement with and has been designated by a Host Blue as a member of its BlueCard PPO Network under the BlueCard program. When a Provider of the First Priority Life PPO Network, the Highmark Blue Shield PPO Network, or the Host Blue PPO Network Provider is used by Participants of the Agreement, coverage will be provided at the Preferred Provider level.

- **NON-PREFERRED PARTICIPATING PROVIDER** – A Provider who has not signed a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, but is a Provider who has signed a Provider Agreement with and has been designated by a Host Blue as a "Participating Provider" under the BlueCard program.

- **NON-PREFERRED PARTICIPATING FACILITY PROVIDER** – A Facility Provider does not have a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider program, but is a Provider that has signed a Provider Agreement with and has been designated by the Host Blue as a "Participating Provider" under the BlueCard program. When the Host Blue Network Provider is used by Participants, coverage will be provided at the Non-Preferred Provider level, with the exception of an Emergency Service.

- **NON-PREFERRED PARTICIPATING PROFESSIONAL PROVIDER** – A Professional Provider who does not have a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider program, but is a Professional Provider who has signed a Provider Agreement with and has been designated by the Host Blue as a "Participating Provider" under the BlueCard program. When the Host Blue Network is used by Participants, coverage will be provided at the Non-Preferred Provider level, with the exception of an Emergency Service.

- **NON-PREFERRED PROVIDER** – A Provider who has not signed a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and who has not signed a Provider Agreement with and is not a member of the Host Blue BlueCard PPO Network nor is otherwise designated by a Host Blue as a "Participating Provider" under the BlueCard program.

- **NON-PREFERRED FACILITY PROVIDER** – A Facility Provider who does not have a Provider Agreement with First Priority Life and/or the Highmark Blue Shield, as applicable, pertaining to payment for Covered Services rendered to an Insured enrolled in a Preferred Provider program, and who has not signed a Provider Agreement with and is not a member of the Host Blue BlueCard PPO Network nor is otherwise designated by a Host Blue as a "Participating Provider" under the BlueCard program. When services are provided by a Non-Preferred Facility Provider, coverage will be provided at the Non-Preferred Provider level, with the exception of an Emergency Service.

- **NON-PREFERRED PROFESSIONAL PROVIDER** – A Professional Provider who does not have a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and who has not signed a Provider Agreement with and is not a member of the Host Blue BlueCard PPO Network nor is otherwise designated by a Host Blue as a "Participating Provider" under the

  BlueCard Program. When services are provided by a Non-Preferred Professional Provider, coverage will be provided at the Non-Preferred Provider level, with the exception of an Emergency Service.

83. PROVIDER AGREEMENT – An agreement between a Provider and First Priority Life and/or Highmark Blue Shield, as applicable, or any other Blue Plan (Host Blue) pursuant to which negotiated rates are established for payment of Covered Services rendered to Participant.

84. PSYCHIATRIC CARE – Direct or consultative service provided by a Physician who specializes in psychiatry.

85. PSYCHIATRIC HOSPITAL – A Facility Provider, approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

86. PSYCHOLOGICAL CARE – Direct or consultative services provided by a Psychologist.

87. PSYCHOLOGIST – A licensed clinical Psychologist.

88. RECONSTRUCTIVE PROCEDURE/SURGERY – Procedures, including surgical procedures, performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from disease, accidental injury, or a previous therapeutic process. This includes a surgical procedure performed on one breast or both breasts following a Mastectomy, as determined by the treating Physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the Mastectomy and it includes, but is not limited to: augmentation mammoplasty, reduction mammoplasty and mastopexy.

89. REGISTERED NURSE (RN) – A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

90. REHABILITATION HOSPITAL – A Facility Provider approved by the appropriate accrediting agency or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

91. REHABILITATIVE CARE – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

92. RESPITE CARE – Residential Medical Care given in a setting outside the patient's home, such as in a Skilled Nursing Facility, in order to provide a brief interval of relief for the patient's primary caregiver, which is usually a family

member.

93. RETAIL CLINIC CARE – The treatment of common minor ailments (in a health care facility located in a convenient setting, such as a retail store, grocery store or pharmacy, which offers unscheduled, walk-in care) including, but not limited to, sore throat, coughs or pink eye.

94. SEMI-PRIVATE ROOM – The bed, board and nursing care regularly provided to patients in a room which is designated as semi-private by the Provider of care and which contains more than one bed.

95. SERIOUS MENTAL ILLNESS – Any of the following mental illnesses, as defined by the American Psychiatric Association; schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder

96. SERVICE AREA – The following thirteen (13) Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

97. SKILLED NURSING FACILITY – A Facility Other Provider, which is an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental disorders, alcoholism or drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested.

98. SUBSTANCE ABUSE – 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.

99. SUBSTANCE ABUSE TREATMENT FACILITY – A licensed Facility Provider, which is primarily engaged in Detoxification and/or rehabilitation treatment for Alcohol and/or Drug Abuse. The Facility Provider must meet the minimum standards for such facilities set by the Pennsylvania Department of Health.

100. SUPPLIER – An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.

101. SURGERY – The performance of generally accepted operative and cutting procedures, including specialized instrumentations, endoscopic examinations and other procedures; the correction of fractures and dislocations; and usual and related pre-operative and post-operative care.

102. THERAPEUTIC CARE – Services provided by Speech Language Pathologists, Occupational Therapists or Physical Therapists.

103. THERAPY SERVICE – Services or supplies used for the treatment of an illness or injury to promote the recovery of a Participant. Therapy Services are covered to the extent specified in the Agreement.

a. CARDIAC REHABILITATION THERAPY – An exercise program, which is effective in the physiological and psychological rehabilitation of patients with cardiac conditions.

b. COGNITIVE REHABILITATION THERAPY – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain injury.

c. DIALYSIS TREATMENT – The treatment of acute renal failure or chronic irreversible renal insufficiency or removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

d. OCCUPATIONAL THERAPY – The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish

the ordinary tasks of daily living and those required by the person's particular occupational role.

e. **PHYSICAL THERAPY** – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part performed by a licensed Physical Therapist.

f. **PULMONARY REHABILITATION THERAPY** – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders.

g. **RADIATION THERAPY** – The treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

h. **RESPIRATORY THERAPY** – The introduction of dry or moist gases into the lungs for treatment purposes.

i. **SPEECH THERAPY** – The treatment for the correction of a speech impairment resulting from disease, Surgery, injury, anomalies or previous therapeutic processes.

104. **TRANSITIONAL LIVING FACILITY** – A facility that renders Long-Term Residential Care. This type of facility can be licensed, when appropriate, by the Pennsylvania Department of Health. However, a facility providing Long-Term Residential Care is not to be considered an Inpatient Non-Hospital Residential Facility rendering Inpatient Non-Hospital Residential Care. Specific Transitional Living Facilities include half-way houses, group homes or supervised apartment settings.

105. **TREATMENT PLAN FOR ASD** – A plan for the treatment of Autism Spectrum Disorders 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.

106. **UNATTENDED SERVICES –** Services that are not accompanied by a Provider or monitored by a Provider.

107. **URGENT CARE –** The provision of immediate medical service offering outpatient care (in a facility dedicated to the delivery of unscheduled, walk-in care outside of a hospital emergency department) for the treatment of acute and chronic illness or injury.

CARE COORDINATION

Subject to the exclusions, conditions, and limitations of the Agreement, a Participant is entitled to Covered Services under the Agreement, provided that components of the care coordination plan are followed. This program provides for two primary levels of Covered Services for most Covered Services, depending upon the Provider selected for such Covered Services. Covered Services and payment allowances are described in ***the Outline of Coverage***.

A. SELECTION OF PROVIDERS

A Participant covered under the Agreement has the option of choosing where and to whom to go for Covered Services.

Covered Services may be rendered by a Preferred Provider, a Non-Preferred Participating Provider, or a Non- Preferred Provider.

B. EMERGENCY SERVICES

In the event that the Participant requires Emergency Service, First Priority Life will provide coverage at the Preferred Provider level and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been incurred if the Participant had been able to choose a Preferred Provider. For Inpatient emergency admissions to a Non-Preferred Provider, the Participant is responsible for notifying First Priority Life or its designated agent within forty-eight (48) hours of the Emergency Service or as soon as reasonably possible. Once an Insured is stabilized, to continue coverage at the higher reimbursement level, First Priority Life reserves the right to transfer the Participant's care from a Non-Preferred Provider to a Preferred Provider.

C. MEDICALLY NECESSARY SERVICES

Medical Necessity for Covered Services will be initially determined prior to the service being rendered when Pre- Certification is required. When Pre-Certification is not required, First Priority Life may determine that a service was not Medically Necessary after service has been rendered. First Priority Life only covers services, which it determines to be Medically Necessary. The Participant should be aware that services may be denied for lack of Medical Necessity after the service has been rendered. Therefore, if a Participant has a concern about a service requiring Pre-Certification, he/she should contact the Pre-Certification Department of First Priority Life prior to the service being rendered.

Based upon the evidence as required, First Priority Life shall determine the Medical Necessity for Covered Services. However, the Participant shall have the right to appeal such determinations as set forth in the Agreement.

D. EXPERIMENTAL/INVESTIGATIVE TREATMENT

The Agreement does not cover services, which First Priority Life initially determines to be Experimental or Investigative in accordance with the procedure outlined. However, First Priority Life recognizes that situations occur when a Participant elects to pursue Experimental or Investigative treatment. If the Participant receives a service which First Priority Life considers to be Experimental or Investigative, the Participant may be solely responsible for payment of these services. The Participant or the Provider may contact the Pre-Certification Department of First Priority Life to determine whether First Priority Life considers a service to be Experimental or Investigative.

E. TO REQUEST PRE-CERTIFICATION

For other than mental health care and Home Infusion Therapy Services, Pre-Certification can be obtained by contacting the Pre-Certification Department of First Priority Life at 1-866-262-5623 or at the following address:

Pre-Certification Department First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711

The telephone number for Pre-Certification for mental health care Covered Services is 1-800-577-3742.

Pre-Certification for Home Infusion Therapy can be obtained by contacting the Pharmacy Management Department of First Priority Life at 1-800-722-4062 or at the following address:

Pharmacy Management Department First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711-0302

F. PRE-CERTIFICATION OF SERVICES

1. Services

Pre-Certification is required to determine Medical Necessity for services and in order to allow Participants to maximize Covered Service in the Agreement.

With the exception of Emergency Service, or a maternity admission, Pre-Certification is required prior to Inpatient admissions in a Hospital, Skilled Nursing Facility, Rehabilitation Hospital or Psychiatric Hospital. Pre-Certification in a facility of a Preferred Provider is required for *certain* diagnoses and Surgeries when performed as an Inpatient. All Inpatient Surgeries and diagnoses in a facility of a Non-Preferred Participating/Non-Preferred Provider require Pre-Certification. Transplant Surgery, however, always requires Pre-Certification, regardless of the facility.

Certain procedures/Surgeries performed in an acute-care Hospital's short procedure unit or free-standing surgical facility and *certain* diagnostic tests/scans require Pre-Certification, regardless of Provider.

Pre-Certification for Inpatient or Outpatient Covered Services is waived in the case of an Emergency Service or maternity admission. However, the Provider or the Participant must submit notification to First Priority Life of the Inpatient emergency admission within forty-eight (48) hours or as soon as reasonably possible.

Except for the home health care visit following a Mastectomy or the postpartum visit, Pre-Certification is required for home health care and for Home Infusion Therapy, regardless of Provider.

Certification refers only to the Medical Necessity of the services. Once the certified admission or treatment takes place, payment of Covered Services is subject to the Participant's eligibility on the date of service.

2. Providers

The Participant is responsible to confirm with a BlueCare Service Representative that their Provider obtained Pre-Certification prior to the service being rendered.

Preferred Providers and Non-Preferred Participating Providers: Preferred Providers and Non-Preferred Participating Providers are responsible for obtaining Pre-Certification on behalf of a Participant. These Providers must accept First Priority Life's determination of Medical Necessity and may not bill the Participant for services, which First Priority Life determines are not Medically Necessary, unless, of course, the Participant or Provider received prior notice that the service or admission would not be covered but nonetheless elected to undergo the treatment or be admitted.

A Participant will not be responsible for payment when the Pre-Certification was requested and First Priority Life denied the service or admission because it was not Medically Necessary, yet the Provider admitted the Participant or provided the treatment.

Non-Preferred Providers: The Participant is responsible to confirm with a BlueCare Service Representative that their Non-Preferred Provider obtained Pre-Certification prior to the service being rendered. A Non-Preferred Provider is not obligated to accept First Priority Life's determination, and therefore, may bill the Participant for services determined not to be Medically Necessary. The Participant is solely responsible for payment for such services. The Participant can avoid this responsibility by choosing a Preferred Provider or a Non-Preferred Participating Provider.

3. Penalty

Except for Inpatient emergency or maternity admissions, should the Participant fail to obtain Pre-Certification from a Non-Preferred Provider, as required; the Participant will be liable for payment of a penalty as indicated on ***the Outline of Coverage*** for the Covered Services, even though the services were Medically Necessary.

In the event, however, that the Participant requires Emergency Service, First Priority Life will provide coverage at the Preferred Provider level and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been incurred if the Participant had been able to choose a Preferred Provider.

Penalties for failure to obtain Pre-Certification will not be applied to the Participant's Coinsurance Maximum.

First Priority Life only covers services, which it determines to be Medically Necessary. Should the Participant fail to obtain

Pre-Certification from a Non-Preferred Provider, as required, and it is determined that the service was not Medically Necessary, the Participant will be liable for the full cost of any services rendered.

G. CONCURRENT REVIEW

A review by a utilization review entity of all reasonably necessary supporting information, which occurs during a Participant's Hospital stay or course of treatment and results in a decision to approve or deny payments for health care services. This involves a review of all clinical information and current treatment plans. This ensures that treatment is Medically Necessary and/or being provided in the most appropriate setting. Concurrent review is performed on select Inpatient and ancillary services.

H. CASE MANAGEMENT

Notwithstanding anything in the Agreement to the contrary, First Priority Life may elect to provide Covered Services pursuant to an approved Alternative Treatment Plan for services that would otherwise not be covered. All decisions regarding the implementation of alternative care or alternative treatment to be provided to a Participant shall remain the responsibility of the treating Physician and the Participant. The Participant has the right, at any time, to have the Alternative Treatment Plan discontinued.

First Priority Life shall provide such alternative Covered Services only when and for so long as it determines that the services are Medically Necessary, cost effective relative to Covered Services that would otherwise be covered and subject to a documented Alternative Treatment Plan specifying the alternative Covered Services and their cost efficacy. The total Covered Services paid for such services will not exceed the total Covered Services to which the Participant would otherwise be entitled under the agreement in the absence of alternative Covered Services.

If First Priority Life elects to provide alternative Covered Services for a Participant in one instance, it shall not be obligated to provide the same or similar Covered Services for any Participant in any other instance, nor shall it be construed, as a waiver of its right to administer the Agreement thereafter in strict accordance with its expressed terms.

SCHEDULE OF COVERED SERVICES FOR MEDICAL EXPENSES

Subject to the exclusions, conditions and limitations of the Agreement, a Participant is entitled to Covered Services described in the Agreement and is responsible for the Deductible, Copayment and Coinsurance, if any, as specified herein and in ***the Outline of Coverage***. ***The Outline of Coverage specifies the Benefit Period selected by the Plan.***

For services, which are not provided by a Preferred Provider, the Participant will be responsible for the Application of a higher Coinsurance level as described in ***the Outline of Coverage***. A charge for a Covered Service shall be considered incurred on the date the service or supply was provided to a Participant.

COPAYMENT – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth on ***the Outline of Coverage***.

DEDUCTIBLE (Preferred Provider) – Unless otherwise noted, the Deductible applies to all Covered Services, including Inpatient services and supplies resulting from an accident or Emergency Medical Condition. Services to which the Deductible does not apply are as follows: Outpatient Emergency Services, emergency ambulance, Physician office visits, removal of bony impacted wisdom teeth[2], pediatric and adult immunizations, routine gynecological examinations and Pap Smears, postpartum home health care visit, Metabolic Formulas, Nutritional Therapy, mammograms, routine colorectal cancer screenings, routine prostate cancer screenings, and preventive drugs. Amounts incurred toward the Preferred Provider Deductible will not be applied to the Non-Preferred Participating/NonPreferred Provider Deductible. ***The Outline of Coverage specifies the Deductible amount.***

DEDUCTIBLE (Non-Preferred Participating/Non-Preferred Provider) – Unless otherwise noted, the Deductible applies to all Covered Services, including Inpatient services and supplies resulting from an accident or Emergency Medical Condition. Services to which the Deductible does not apply are as follows: Outpatient Emergency Services, emergency ambulance, pediatric immunizations, routine gynecological examinations and Pap Smears, postpartum home health care visits, Metabolic Formulas, mammograms, routine colorectal cancer screenings, and routine prostate cancer screenings.

Amounts incurred toward the Non-Preferred Participating/Non-Preferred Provider Deductible will also be applied to the Preferred Provider Deductible. ***The Outline of Coverage specifies the Deductible amount.***

FAMILY DEDUCTIBLE (Preferred Provider and Non-Preferred Participating/Non-Preferred Provider) – The eligible Deductible amounts, which are incurred by three (3) separate family members covered under the Agreement or as ***the Outline of Coverage*** indicates may be contributed to the family Deductible, which is three (3) times the amount for an individual in a Benefit Period or as ***the Outline of Coverage*** indicates. No one family member's Deductible expense may exceed the individual Deductible. Deductible and Coinsurance amounts for family members that did not satisfy the individual limits will not be refunded in the event the family Deductible or family Coinsurance Maximum is met by three (3) separate family members.

OR

FAMILY DEDUCTIBLE (Preferred Provider and Non-Preferred Participating/Non-Preferred Provider) – The eligible Deductible amounts contribute to the family Deductible which is two (2) times the individual Deductible amount or as ***the Outline of Coverage*** indicates. The eligible Deductible amounts, which are incurred by any combination of family members covered under the Agreement in a Benefit Period, contribute to the family Deductible. No one family member's Deductible expense may exceed the individual Deductible amount.

Deductible amounts incurred toward the Preferred Provider Deductible amounts incurred toward the Non-Preferred Participating/Non-Preferred Provider Family Deductible will also be applied toward the Preferred Provider Family Deductible.

COINSURANCE (Preferred Provider) is specified in ***the Outline of Coverage***. For the removal of bony impacted wisdom teeth and Ostomy Supplies, the Coinsurance is paid at 50% of the Allowable Charge or as indicated on ***the Outline of Coverage***. Coinsurance applies to all Covered Medical Expenses when a Copayment is not applicable. Coinsurance also does not apply to the postpartum home health care visit pediatric and adult immunizations, routine gynecological examinations and pap smears, mammograms, routine colorectal cancer screenings, routine
prostate cancer screenings, Nutritional Therapy and emergency ambulance transport for Mental or Nervous Disorder or Alcohol and/or Drug Abuse.

COINSURANCE (Non-Preferred Participating/Non-Preferred Provider) is specified in ***the Outline of Coverage***. Coinsurance applies to all Covered Medical Expenses with the exception of the postpartum home health care visit and emergency ambulance transport for Mental or Nervous Disorder or Alcohol and/or Drug Abuse, and when a Copayment is not applicable. Covered Services provided by a Non-Preferred Participating/Non-Preferred Provider for Outpatient Emergency Services are payable at a rate at which the Participant will not incur a greater Out-Of-Pocket expense than would had been incurred had the Participant been able to choose a Preferred Provider.

[2] Coverage for the removal of bony impacted wisdom teeth is limited to services of Preferred Providers as described in the Description of Covered Services Section of the Agreement.

COINSURANCE MAXIMUM (Preferred Provider) – When a Participant incurs the amount of Out-Of-Pocket expense as specified in ***the Outline of Coverage*** in a Benefit Period for Covered Medical Expenses, the Coinsurance percentage will be reduced to **0%** for the balance of that Benefit Period, except for the removal of bony impacted wisdom teeth and Ostomy Supplies which are paid at **50%** of the Allowable Charge or as ***the Outline of Coverage*** indicates.

Coinsurance incurred toward the Preferred Provider Coinsurance Maximum will not be applied to the Non-Preferred Participating/Non-Preferred Provider Coinsurance Maximum.

COINSURANCE MAXIMUM (Non-Preferred Participating/Non-Preferred Provider) – When a Participant incurs the amount of Out-Of-Pocket expenses as specified in ***the Outline of Coverage*** in a Benefit Period for Covered Medical Expenses, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period.

Coinsurance incurred toward the Non-Preferred Participating/Non-Preferred Provider Coinsurance Maximum will also be applied to the Preferred Provider Coinsurance Maximum.

The **Coinsurance Maximum for Preferred** and **Non-Preferred Participating/Non-Preferred Providers** does not include penalties for failure to obtain Pre-Certification, Deductibles, Copayments, amounts in excess of Allowable Charge, charges for non-Covered Services, charges for the removal of bony impacted wisdom teeth when the service is performed by a Preferred Provider which are paid at **50%** of the Allowable Charge or as ***the Outline of Coverage*** indicates, charges after Covered Medical Expenses have been exhausted, and any Deductible, Copayment or Coinsurance amounts payable by the Participant for Covered Services under the Agreement.

FAMILY COINSURANCE MAXIMUM (Preferred Provider and Non-Preferred Participating/Non-Preferred Provider) – The eligible Coinsurance amounts, which are incurred by three (3) separate family members covered under the

Agreement or as ***the Outline of Coverage*** indicates, may be contributed to the family Coinsurance Maximum. When three (3) separate Participants covered under the same Family Coverage have incurred the Coinsurance Maximum for a family for a Benefit Period, which is three (3) times the amount for an individual or as ***the Outline of Coverage*** indicates the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period, except for the removal of bony impacted wisdom teeth and Ostomy Supplies when the services are performed by a Preferred Provider which are paid at **50%** of the Allowable Charge or as ***the Outline of Coverage*** indicates. No one family member's Coinsurance may exceed the individual limits. Deductible and Coinsurance amounts for family members that did not satisfy the individual limits will not be refunded in the event the family Deductible or family Coinsurance Maximum is met by three (3) separate family members.

OR

FAMILY COINSURANCE MAXIMUM (Preferred Provider and Non-Preferred Participating/Non-Preferred Provider) – The eligible Coinsurance amounts contribute to the family Coinsurance Maximum which is two (2) times the individual coinsurance Maximum. The eligible Coinsurance Maximum amounts, which are incurred by any combination of family Participants covered under the Agreement in a Benefit Period, contribute to the family Coinsurance Maximum.

No one family Participant must meet the individual Coinsurance Maximum amount. No one family Participant may exceed the individual Coinsurance Maximum amount. No family pays more than the total family Coinsurance Maximum amount. When one (1) family Participant meets the individual Coinsurance Maximum amount, the eligible Coinsurance percentage for the one (1) family Participant will be reduced to 0% for the balance of the Benefit Period, except for the removal of bony impacted wisdom teeth and Ostomy Supplies when the services are performed by a Preferred Provider which are paid at 50% of the Allowable Charge.

When the family Coinsurance Maximum is met by any combination of remaining family members, the eligible Coinsurance percentage for the family members will be reduced to 0% for the balance of the Benefit Period, except for the removal of bony impacted wisdom teeth and Ostomy supplies when the services are performed by a Preferred Provider which are paid at 50% of the Allowable Charge or as ***the Outline of Coverage*** indicates.

Coinsurance incurred toward the Preferred Provider Family Coinsurance Maximum will not be applied to the Non- Preferred Participating/Non-Preferred Provider Family Coinsurance Maximum.

Coinsurance incurred toward the Non-Preferred Participating/Non-Preferred Provider Family Coinsurance Maximum will also be applied to the Preferred Provider Family Coinsurance Maximum.

MEDICAL LIFETIME BENEFIT MAXIMUM (Preferred Provider and Non- Preferred Participating/Non-Preferred Provider) – Unlimited per lifetime, per Participant or as indicated on ***the Outline of Coverage***.

CROSS PRODUCT ACCUMULATION – If a Participant changes products offered by First Priority Life, its affiliated companies (Blue Cross of Northeastern Pennsylvania, Highmark Blue Shield, or First Priority Health) while with the same Policy Holder during a Benefit Period, or if a Participant changes Deductibles during a Benefit Period while with the same Agreement, eligible expenses, which were applied to the original Deductible and Coinsurance Maximum, will be eligible for credit towards the new Deductible and Coinsurance Maximum amounts during the remainder of that same Benefit Period. Cross Product Accumulation will apply to the Preferred Provider Deductible and Coinsurance Maximum amounts.

PRO-RATION OF DEDUCTIBLE AND PRIOR CARRIER CREDIT - The "Credit" section on the Outline of Coverage specifies the option selected by the Plan.

PRO-RATION OF DEDUCTIBLE – If the Plan Effective Date falls within the last nine (9) months of a Calendar Year, the Deductible under the Agreement will be prorated for the number of quarters remaining in that Calendar Year. For example, a policy with a Calendar Year Deductible would be prorated as follows:

Policy Effective Date	Initial Benefit Period
April-June	75% of Deductible
July-September	50% of Deductible
October-December	25% of Deductible

The initial Benefit Period is the period of time from the initial Effective Date of the Plan through the end of the Calendar Year in which the Plan enrolled.

PRIOR CARRIER CREDIT – If the Plan changes carriers during a Plan's Benefit Period, Covered Expenses which were

incurred and applied to the Deductible and Coinsurance Maximum by the prior carrier during such Benefit Period shall be credited by First Priority Life toward the initial Benefit Period under this new Agreement for those Eligible Employees and Dependents who are enrolled with the Plan during the initial Benefit Period. Prior Carrier Credit will be applied to the Preferred Provider Deductible and Coinsurance Maximum amounts only.

In order for First Priority Life to accept and apply Deductible and/or Coinsurance Maximum amounts, the Plan, the Participant or their prior carrier must supply the required data. If the required data is insufficient and/or not received prior to the Effective Date of the Agreement, First Priority Life reserves the right not to apply this provision.

The initial Benefit Period is the initial Effective Date of the Plan.

DESCRIPTION OF COVERED SERVICES

Subject to the exclusions, conditions and limitations of the Agreement, a Participant is entitled to Covered Services described in the Agreement, in accordance with the Deductible, Copayment and Coinsurance, if any, and in the amounts as specified herein and in ***the Outline of Coverage***. ***The Outline of Coverage also specifies the Benefit Period selected by the Plan.***

The Participant is always responsible for Copayments, Deductibles and Coinsurance in the amounts shown for Covered Services as included herein, in the Outline of Coverage that accompanies the Agreement.

Pre-Certification requirements must be followed as discussed in Section CC - Care Coordination. Inpatient emergency admissions must be reviewed within forty-eight (48) hours of the admission, or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what has been Pre-Certified by First Priority Life.

Covered Services are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

a. a Semi-Private Room, as designated by the Hospital; or a private room, when designated by First Priority Life as semi-private for the purposes of the Agreement, in Hospitals having primarily private rooms;

b. a private room. The private room allowance is the Semi-Private Room charge;

c. a special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;

d. a bed in a general ward; and

e. nursery facilities.

Covered Services are payable for a length of stay following a Mastectomy that a treating Physician determines is necessary to meet generally accepted criteria for safe discharge.

Covered Services are payable for hospital services for an Inpatient admission resulting from an accident or Emergency Medical Condition that a treating Physician determines is medically necessary.

Covered Services are provided for an unlimited number of days per Benefit Period.

In computing the number of days of Covered Services, the day of admission, but not the date of discharge, shall be counted. If the Participant is admitted and discharged on the same day, it shall be counted as one day.

Days available under the Agreement shall be allowed only during uninterrupted stays in a Hospital. Covered Services shall not be provided: (1) for any day during which a Participant interrupts his/her stay; or (2) after the discharge hour that the Participant’s attending Physician has recommended that further Inpatient care is not required.

2. Ancillary Services

Covered Services are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items), including, but not limited to the following:

a) meals, including special meals or dietary services as required by the patient's condition;

b) use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;

c) casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by First Priority Life;

d) oxygen and oxygen therapy;

e) administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Subsection Y - Blood and Blood Plasma of this Section;

f) anesthesia and the supplies and use of anesthetic equipment;

g) Diagnostic Services;

h) Therapy Services;

i) Inpatient rehabilitation therapy limited to forty-five (45) days per Benefit Period or as ***the Outline of Coverage*** indicates;

j) all FDA-approved drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;

k) use of special care units, including, but not limited to, intensive or coronary care; and

l) pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a diagnosis. Covered Services for pre-admission testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancels or postpones the admission, Covered Services will be provided.

Covered Services are payable for ancillary services provided for and billed for by the Hospital for an Inpatient admission resulting from an accident or Emergency Medical Condition.

B. OBSERVATION STATUS

Services furnished on a Hospital's premises include use of a bed and periodic monitoring by Hospital's nursing or other staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital as an Inpatient.

C. EMERGENCY CARE COVERED SERVICES

Emergency care Covered Services include treatment and services provided in the Outpatient department of a Hospital for an Emergency Medical Condition.

- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of bodily injury resulting from an accident shall be covered.

- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of a medical condition with acute symptoms, which would result in requiring immediate Medical Care, shall be covered.

If accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical Covered Services.

Visits which are performed in the Outpatient department of a Hospital that are follow-up to emergency accident care and emergency Medical Care are classified and payable as Outpatient Covered Services.

D. SURGERY

1. Surgical Covered Services

Surgery Covered Services will be provided for services rendered by a Professional Provider and/or Facility Provider in a Physician's office or in a short procedure unit, Hospital, Outpatient department, or Freestanding Outpatient Facility for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all post-operative care normally provided by the surgeon as part of the surgical procedure.

For questions concerning Pre-Certification, the Participant should contact First Priority Life by calling a BlueCare Service Representative prior to the service being rendered. Ambulatory Surgery (i.e., Surgery performed in an acute-care Hospital's short procedure unit or a free-standing surgical facility) requires Pre- Certification by First Priority Life for *certain* procedures, regardless of Provider. Outpatient Surgery (i.e., Surgery performed in a Physician's office or in an acute-care Hospital's Outpatient department) also requires Pre-Certification of *certain* procedures by First Priority Life regardless of Provider.

- Upon Pre-Certification, Surgery Covered Services are covered for the surgical treatment of Morbid Obesity, provided the Participant is at least eighteen (18) years of age or as indicated on ***the Outline of Coverage***. This Covered Service is limited to one (1) procedure per lifetime. If the preferred Coinsurance on ***the Outline of Coverage*** indicates "none," a Copayment of **$2,000** applies after Deductible, if any, for the procedure when performed by a Preferred Provider. Otherwise, the Deductible and Coinsurance specified on ***the Outline of Coverage will apply.***

- When a panniculectomy is Medically Necessary, upon Pre-Certification it is limited to one (1) procedure per lifetime for those eighteen (18) years of age or older or as indicated on ***the Outline of Coverage***. If the preferred Coinsurance on ***the Outline of Coverage*** indicates "none," a Copayment of **$1,000** applies, after Deductible, if any, for the procedure when performed by a Preferred Provider. Otherwise, the Deductible and Coinsurance specified on ***the Outline of Coverage*** will apply.

- Reconstructive Surgery will only be covered when required to restore function following accidental injury, infection, or disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of eighteen (18); or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy.

- Covered surgical procedures shall also include routine neonatal circumcision or as indicated on ***the Outline of Coverage***. Voluntary surgical procedures for sterilization regardless of Medical Necessity and Surgery performed for the reversal of sterilization are not covered or as indicated on ***the Outline of Coverage***.

- Covered Services are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:

    a. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;

    b. Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and

    c. Physical complications of all stages of Mastectomy, including lymphedemas.

Coverage is also provided for one (1) home health care visit, as determined by the Participant's Physician, received within forty-eight (48) hours after discharge.

- The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus is covered.

2. Assistant Surgeon

Covered Services will be payable for services by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery for a Participant. The condition of the Participant or the type of Surgery must require the active assistance of an assistant surgeon as determined by First Priority Life. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

3. Removal of Bony Impacted Wisdom Teeth

The removal of partially or totally bony impacted wisdom teeth, when performed by a Preferred Professional Provider in other than a Hospital or Ambulatory Surgical Facility, will be covered.

The Surgery may occur in a Hospital or Ambulatory Surgical Facility if authorized by a Medical Director of First Priority Life for:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Participant's health.

General anesthesia charges will be covered for removal of bony impacted wisdom teeth in a Hospital or Ambulatory Surgical Facility if authorized by a Medical Director of First Priority Life for:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Participant's health.

Local anesthesia and conscious sedation are covered regardless of setting.

4. Physician, Hospital or Ambulatory Surgical Facility Charges for Dental Procedures or Dental Surgery

Dental procedures are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions. Covered Services will be payable for Physician, Hospital or Ambulatory Surgical Facility charges in connection with dental procedures or dental Surgery performed in a Hospital or Ambulatory Surgical Facility when approved by a Medical Director of First Priority Life under the following circumstances:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health, or
- When one of the following is present:

    a. It is a required part of a broader treatment plan requiring radiation of the head and/or neck.

    b. There is non-dental disease eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Participant's teeth.

    c. There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant.

5. Oral Surgery

Oral Surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Service only for treatment of diseases and injuries of the jaw, head and neck. Surgery for the treatment of diseases of the teeth or gums, are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions.
Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures are excluded from Covered Services for oral Surgery unless such procedures were for the treatment of accidental bodily injury or as described in

Subsection D, Paragraph 4 above.

6. Dental Services related to Accidental Injury

Dental services rendered by a Professional Provider and/or a Facility Provider, as a result of accident injury to the jaws, natural teeth, mouth or face, are covered when performed for immediate post injury stabilization. Injury as a result of chewing or biting shall not be considered an accidental injury.

Dental implants are excluded from benefits as set forth in the Exclusions or as specified by the Plan Specific Exclusions.

7. Dental Services Related to Early Childhood Caries (ECC)

Dental services directly associated with early childhood caries (ECC), prior to age four (4), are limited to one (1) treatment per Participant per lifetime.

8. Eyeglasses or Contact Lenses following Surgery

Coverage will be provided for eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e., cataract Surgery) or injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:

1) contact lenses used for treatment of infantile glaucoma;

2) corneal or scleral lenses prescribed in connection with the treatment of keratoconus;

3) scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and

4) corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

Coverage will be provided for the initial prescription of cataract glasses or contact lenses, with or without an implant, after cataract Surgery. Post-cataract prescription glasses or contact lenses are limited to a Lifetime Benefit Maximum of $350 per Participant or as ***the Outline of Coverage*** indicates. This Maximum allowance includes both eyes.

E. ANESTHESIA

Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility when in connection with the performance of Covered Services and when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider is covered.

Coverage for general anesthesia in connection with the extraction of partially or totally bony impacted wisdom teeth is described in Subsection D, Surgery, Paragraph 3 above.

Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with the performance of non-covered dental procedures or non-covered oral Surgery is covered when approved by a Medical Director of First Priority Life under the following circumstances:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health, or
- When one of the following is present:
    1) It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
    2) There is non-dental diseases eroding or invading the maxilla and/or mandible, the treatment of

which necessitated removal of the Insured Person's teeth.

3) There is infection of the teeth and gums that places the Insured Person's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant.

Local anesthesia and conscious sedation are covered regardless of setting.

F. SECOND SURGICAL OPINION

Second opinion consultations for Surgery to determine the Medical Necessity of an elective surgical procedure are covered. Elective Surgery is Surgery that is not for an emergency or life-threatening condition.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

G. TRANSPLANT SURGERY If a human organ or tissue transplant is provided from a human donor to a human transplant recipient:

1. When both the recipient and the donor are Participants, each is entitled to the Covered Services of the Agreement.

2. When only the recipient is a Participant, both the donor and the recipient are entitled to the Covered Services of the Agreement. The donor Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to: other insurance coverage, or coverage by First Priority Life or any government program. Covered Services provided to the donor will be charged against the recipient's coverage under the Agreement to the extent Covered Services remain and are available under the Participant after the Covered Services of the recipient have been paid.

3. When only the donor is a Participant, the donor is entitled to the Covered Services of the Agreement. The Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by First Priority Life or any government program available to the recipient. No Covered Services will be provided to the non-Participant transplant recipient.

4. If any organ or tissue is sold rather than donated to the Participant recipient, no Covered Services will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Participant recipient's Agreement limit.

5. If the Participant's coverage includes Prescription Drug coverage, the immunosuppressant drugs in connection with covered transplants will be provided under the Prescription Drug Coverage Section of the Agreement and the cost for these drugs is detailed in ***the Outline of Coverage***.

Pre-Certification is required as set forth in Section CC – Care Coordination.

H. CONCURRENT CARE

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Participant, standby services, routine pre-operative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

I. CONSULTATIONS

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations, which are required by Facility Provider's rules and regulations.

Covered Services are limited to one (1) consultation per consultant during any Inpatient confinement.

J. PHYSICIAN OFFICE VISITS

Covered Services are provided for Medical Care, visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient. Covered Services are provided for the examination, diagnosis, and treatment of an illness or injury and routine office visits. Adult care includes routine physical examinations, regardless of their Medical Necessity, including a complete medical history plus necessary Diagnostic Services. With the exception of visits and consultations for Chiropractic Manipulative Treatment, there is an unlimited visit Maximum per Benefit Period. For Chiropractic Manipulative Treatment, the Participant is subject to the combined Maximum included in the Description of Covered Services Section.

K. THERAPEUTIC DRUGS THAT ARE NOT SELF-ADMINISTRABLE

Covered Services are provided for FDA-approved therapeutic drugs, including cancer Chemotherapy and cancer hormone treatment that are not self-administrable and required in the treatment of an illness or injury in all medically appropriate treatment settings covered by the Agreement.

L. DIAGNOSTIC SERVICES-OUTPATIENT

Covered Services are provided for the following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, independent clinical laboratory, and/or a Facility Provider:

1. Diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine.

2. Diagnostic mammograms, which are recommended by a Physician, are covered for all Participants. Diagnostic mammograms performed by a Preferred Provider are exempt from all Deductibles and Maximums.

3. Diagnostic laboratory and pathology tests.

4. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life.

5. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan, and nuclear cardiology studies approved by First Priority Life. If the preferred coinsurance on the ***Outline of Coverage*** indicated "none", a Copayment of **$75** applies, after Deductible, if any, per test/scan. Otherwise, the Deductible and Coinsurance specified in ***the Outline of Coverage*** will apply or as indicated on the ***Outline of Coverage***.

    a. If the diagnostic imaging procedure is rendered in conjunction with an Outpatient emergency room visit,

6. Inpatient admission, observation status, or ambulatory surgical procedure, the **$75** Copayment per test/scan will be waived.

7. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

Certain diagnostic tests/scans require Pre-Certification, regardless of Provider.

M. THERAPY SERVICES-OUTPATIENT

Covered Services shall be provided, subject to the Maximums specified below, for the following services prescribed by a Physician and performed by a Professional Provider and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Participant.

1. Cardiac Rehabilitation Therapy is limited to a Maximum of thirty-six (36) visits or as indicated on ***the Outline of Coverage*** per Benefit Period.

2. Dialysis Treatment.

3. Pulmonary Rehabilitation Therapy is limited to a Maximum of eighteen (18) visits or as indicated on ***the Outline of Coverage*** per Benefit Period.

4. Radiation Therapy, including the cost of radioactive materials.

5. Respiratory Therapy is limited to a Maximum of eighteen (18) visits or as indicated on ***the Outline of***

Coverage per Benefit Period.

6. Short term therapy is Occupational, Physical, or Speech Therapy which:

- is prescribed by a Physician,
- is Medically Necessary to regain lost function after an accidental injury, Surgery, or an acute illness, and
- will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

Outpatient Occupational, Physical, and Speech Therapy Covered Services are limited to:

(a) Occupational Therapy is limited to a Maximum of twelve (12) visits or as indicated on ***the Outline of Coverage*** per Benefit Period.

(b) Physical Therapy is limited to a Maximum of twenty (20) visits or as indicated on ***the Outline of Coverage*** per Benefit Period.

(c) Speech Therapy is limited to a Maximum of twelve (12) visits or as indicated on ***the Outline of Coverage*** per Benefit Period.

7. When Physical, Occupational, and/or Speech Therapy Services are provided to a Participant in conjunction with a Treatment Plan for Autism Spectrum Disorder, the Benefit Period Maximum for these Therapy Services will not be reduced unless the Therapy Service provided is for other than Autism Spectrum Disorder. Once the Benefit Period Maximum has been reached, no additional Physical, Occupational, and/or Speech Therapy benefits are available under the Agreement for the remainder of the Benefit Period for treatment of Autism Spectrum Disorder.

N. MATERNITY SERVICES

Services rendered in the care and management of a pregnancy for a Participant are Covered Services under the Agreement. Covered Services are payable for:

1 Normal Pregnancy

Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy, but not considered a complication of pregnancy.

2 Complications of Pregnancy

Physical effects directly caused by pregnancy, but which were not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

3 Minimum Length of Stay

Coverage will be provided for a minimum of forty-eight (48) hours of Inpatient care following normal vaginal delivery and ninety-six (96) hours of care following cesarean delivery. A shorter length of stay may be justified when the treating or attending Physician determines in consultation with the mother that she and the newborn meet medical criteria for safe discharge in accordance with guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Those guidelines determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant post- discharge; and the availability of the post-discharge follow-up care to verify the condition of the infant and mother within forty-eight (48) hours after discharge.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits 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. The postpartum home health visit is exempt from any Deductibles, Copayments or Coinsurance.

4. Interruptions of Pregnancy

a. Miscarriage.

b. Services, which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest.

5. Nursery Care

Ordinary nursery care of the newborn infants.

6. Routine Newborn Care

The newborn child of any covered Participant, spouse, or Dependent shall be entitled to Covered Services provided by the Agreement from the date of birth up to a Maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care, which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond thirty-one (31) days by enrolling the newborn child as a Dependent under the Agreement, provided that all premium payments required are paid for such child.

If the newborn does not otherwise qualify for coverage as a Dependent, the child will be entitled to Hospital service during the thirty-one (31) days after birth. In order to continue coverage for the newborn beyond this time, enrollment must be within thirty-one (31) days of the date of birth.

Routine neonatal circumcision is covered.

O. ARTIFICIAL INSEMINATION

Artificial insemination is covered for three (3) attempts per lifetime. Associated diagnostic, medical, and surgical services are considered part of the artificial insemination procedure.

P. MENTAL HEALTH CARE SERVICES

Covered Services for the treatment of Mental or Nervous Disorders and for the treatment of Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as mental health care are subject to the mental health care limitations in the Agreement. When a Provider renders Medical Care, other than mental health care, for a Participant with Serious Mental Illness or with a Mental or Nervous Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be subject to the mental health care limitations in the Agreement.

Except in an emergency, Inpatient and Partial Hospitalization Covered Services are provided when Medically Necessary and when the Community Behavioral Healthcare Network of Pennsylvania (CBHNP) is notified by the Provider or the Participant before the Covered Services are rendered. Pre-Certification procedures apply as set forth in Section CC – Care Coordination.

1. Inpatient Services

Inpatient Services will be provided for admissions for Serious Mental Illness and Mental or Nervous Disorders in an Inpatient Mental Health Hospital. Pre-Certification requirements must be followed as discussed in Section CC – Care Coordination. A concurrent review is required for any continued length of stay beyond what has been pre-certified by CBHNP.

2. Outpatient Services

Outpatient services will be provided during a Benefit Period for Mental or Nervous Disorders and for Serious Mental Illness.

Outpatient mental health care services include Outpatient professional visits and Outpatient Partial Hospitalization days.

Q. TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE AND DEPENDENCY

Covered Services are available to a Participant who is certified by a licensed Physician or licensed Psychologist as a person

who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient or Outpatient Substance Abuse treatment. The certification must be provided to Community Behavioral Network of Pennsylvania (CBHNP) before claims for treatment rendered will be processed for payment. The certification by a licensed Physician or licensed Psychologist is valid for thirty (30) days per calendar year. Any treatment beyond thirty (30) days or any subsequent treatment must meet Medical Necessity requirements and will require Pre-Certification as described in Section CC – Care Coordination.

Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Drug and

Alcohol treatment by non-Physicians/Psychologists must be pre-certified with CBHNP before services are rendered and must meet Medical Necessity criteria.

1. Inpatient Detoxification

Covered Services are provided for Inpatient Detoxification when provided in either a Hospital or in an Inpatient Non-Hospital Residential Facility. The following services will be covered when administered by an employee of the facility:

a. lodging and dietary services;

b. rehabilitation therapy and counseling;

c. diagnostic x-ray;

d. psychiatric, psychological and medical laboratory testing; and

e. drugs, medicines, equipment use and supplies.

2. Inpatient Non-Hospital Residential Care

Covered Services are provided for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility.

The following services will be covered when administered by an employee of the facility:

a. lodging and dietary services;

b. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;

c. rehabilitation therapy and counseling;

d. family counseling and intervention;

e. psychiatric, psychological and medical laboratory testing; and

f. drugs, medicines, equipment use and supplies.

3. Outpatient Facility Services for Treatment of Alcohol or Drug Abuse

Covered Services are provided for Outpatient Alcohol and/or Drug Abuse services when provided in a Substance Abuse Treatment Facility. The following services will be covered when administered by an employee of the facility:

a. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;

b. rehabilitation therapy and counseling;

c. family counseling and intervention;

d. psychiatric, psychological and medical laboratory testing; and

e. drugs, medicines, equipment use and supplies.

R. OXYGEN AND RELATED EQUIPMENT/SUPPLIES

Oxygen and related equipment and supplies for use in the patient's home are covered.

S. SKILLED NURSING FACILITY

Covered Services are provided for care in a Skilled Nursing Facility, when determined to be Medically Necessary by First Priority Life, up to sixty (60) days per Benefit Period or as indicated on ***the Outline of Coverage***. The Participant must require treatment by skilled nursing personnel, which can be provided only on an Inpatient basis in a Skilled Nursing Facility. Pre-Certification procedures apply as set forth in Section CC – Care Coordination.

The Participant's attending Physician must provide First Priority Life with clinical information that skilled nursing care in a Skilled Nursing Facility is Medically Necessary pursuant to Section CC – Care Coordination.

No Covered Services are payable:

1. after the Participant has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care;

2. when confinement in a Skilled Nursing Facility is intended solely to assist the Participant with the activities of daily living or to provide an institutional environment for the convenience of a Participant; or

3. for the treatment of alcoholism, drug addiction, or mental illness.

T. HOME HEALTH CARE

Subject to the following provision, Covered Services will be provided for unlimited home health care visits per Benefit Period or as indicated on ***the Outline of Coverage***.

Covered Services will be provided for the following Covered Services when performed by a licensed Home Health Care Agency:

1. professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;
2. home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
3. Physical Therapy treatments performed by a licensed Physical Therapist;
4. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;
5. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;
6. medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;
7. Nutritional Therapy provided by a Licensed Dietitian[3];
8. diagnostic and therapeutic radiology services;
9. laboratory services;

[3] Nutritional Therapy provided to a Homebound Participant will not reduce the Covered Service provided under Number 7of the Description of Covered Services Section of the Agreement.

10. medical diagnostic tests and studies;

11. oxygen and Respiratory Therapy;

12. medical and surgical supplies, including bandages, ostomy supplies, dressings and casts[4]; and

13. the rental of Durable Medical Equipment but only on a short term basis and if not owned by the Home Health Care Agency.

The Participant must be Homebound in order to receive home health Covered Services, except when services are provided in conjunction with:

- Home Infusion Therapy, including the care of venous lines;
- The post Mastectomy visit; and
- The post-partum visit; or
- When services are not routinely provided in a Physician's office or the Outpatient setting and are Medically Necessary and have approval of First Priority Life's Medical Director.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a Mastectomy, Covered Services will be provided for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

Covered Services will be provided only for Services if (a) the services are prescribed by the Participant's attending Physician, (b) the Participant received Pre-Certification approval from First Priority Life as set forth in Section CC - Care Coordination, and (c) the Participant's Physician has furnished, in consultation with the Home Health Care Agency's professional personnel prior to the first visit, a plan of treatment stating that the services are Medically Necessary. Continuing eligibility requires that the attending Physician provide such a plan of treatment at intervals of no less than every thirty (30) days.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Pre- Certification will not be required for this visit.

At the discretion of the mother, a visit may occur at home or at the facility of the Provider. It is necessary to use a Provider included in First Priority Life's network of contracted Providers in order to avoid a Covered Service reduction of the eligible charges, except for Emergency Care or when Covered Services are not available from a Preferred Provider. Postpartum home health care visits are exempt from any Copayment, Coinsurance or Deductible amounts.

No home health care Covered Services will be provided for:

1. food or home delivered meals;

2. professional medical services billed by a Physician;

3. Custodial Care;

4. services of a housekeeper;

[4] Ostomy Supplies provided to a Homebound Participants as part of Home Health Care will not reduce the Covered Services provided in Ostomy Supplies of the Description of Covered Services Section of the Agreement.

5. Private Duty Nursing;

6. ambulance service;

7. drugs, including Prescription Drugs; and

8. services provided by Immediate Family or members of the Participant's household.

U. HOME INFUSION THERAPY

Covered Services will be provided for the following services provided to a Participant by a Home Infusion Therapy Agency:

1. total parenteral nutrition *;
2. enteral nutrition *;
3. intravenous therapy;
4. cancer Chemotherapy and cancer hormone treatment;
5. anti-infective therapy (* Lyme Disease);
6. pain management (continuous and epidural analgesics); and
7. immune globulin therapy *.

The Home Infusion Therapy Agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic benefits and to assure proper functioning of the system, including, but not limited to: catheters, concentrated nutrients, dressings, enteral nutrition preparation, extension tubing, filters, heparin sodium (parenteral only), infusion bottles, IV pole, liquid diet (for catheter administration), needles, pumps, tape and volumetric monitors.

All therapies are subject to prospective, concurrent and/or retrospective utilization review by health care professionals, and further may require Pre-Certification to determine if a therapy is Medically Necessary and appropriate. Before delivering the therapy, a preferred Home Infusion Therapy Agency will advise the Participant if Pre-Certification is required

* Therapies that generally require Pre-Certification are noted with an asterisk above. Any therapy or drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be pre- certified.

Pre-Certification procedures apply as set forth in Section CC – Care Coordination. Home

Infusion Therapy Covered Services will not be provided for:

a. Participants who are receiving Covered Services under the Hospice Care program;
b. blood and blood products therapy; and
c. any injectable drugs covered under any other Covered Services section of the Agreement.

V. METABOLIC FORMULAS

Metabolic Formulas only for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. This Covered Service does not include coverage for normal food products used in the dietary management of rare genetic metabolic disorders. Covered Services for Metabolic Formulas are exempt from any Deductible requirements.

W. HOSPICE CARE

When the Participant's attending Physician certifies to First Priority Life that the Participant has a terminal illness with a life expectancy of six (6) months or less and when the Participant elects to receive care primarily in the home to relieve pain and to enable the Participant to remain at home rather than to receive other types of care, the Participant shall be eligible for Hospice Care Covered Services.

Covered Services for Hospice Care shall be provided for up to one-hundred eighty (180) days or as indicated on ***the Outline of Coverage***. These Covered Services are in addition to, and not in lieu of, any other Covered Services in the Agreement. If the Participant or the Participant's responsible party elects to institute curative treatment to sustain life, the Participant will not be eligible to receive further Hospice Care Covered Services until the cessation of such curative treatment.

The Hospice Care Covered Service will include, coverage for continuous care consisting of nursing care for up to twenty-four (24) hours per day necessary to maintain the patient at home or acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures. A Maximum of thirty (30) days (of the 180- day Lifetime Benefit Maximum) or as indicated on ***the Outline of Coverage*** is available for continuous and/or Inpatient care. Respite Care on a short-term Inpatient basis in a Hospital or Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient's home. Respite Care is available with a Maximum of ten (10) days per lifetime (of the 180-day Lifetime Benefit Maximum) or as indicated on ***the Outline of Coverage***. Covered Services are payable according to the Maximums set forth in herein.

Covered Services will be provided for supportive services at each level of care to a terminally-ill Participant by a Hospice Care program in accordance with a treatment plan approved by and periodically reviewed by First Priority Life. The following services provided to a Participant by an approved Hospice responsible for the patient's overall care will be eligible for coverage:

1. professional services of a Registered Nurse or Licensed Practical Nurse;
2. pain management;
3. Chemotherapy and/or Radiation Therapy;
4. parenteral or enteral nutrition therapy;
5. prescription drugs;
6. laboratory services;
7. dietitian services;
8. medical and surgical supplies, ostomy supplies, and Durable Medical Equipment[5];
9. oxygen and its administration;
10. medical social service consultation provided by a social worker;
11. counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
12. home health aide and homemaker services; and
13. any needed therapies.

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[5] Ostomy Supplies provided to a Participant as part of Hospice Care will not reduce the Covered Services provided under Ostomy Supplies of the Description of Covered Services Section of the Agreement.

X. DIABETES EDUCATION/EQUIPMENT/SUPPLIES Diabetes

Education

Covered Services are provided for diabetes education services as described herein or as indicated on ***the Outline of Coverage***. Diabetes Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician shall include: (1) visits Medically Necessary upon the diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

Diabetic Equipment and Supplies

Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items or as indicated on ***the Outline of Coverage***. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses. Equipment and supplies prescribed as a result of diabetes as set forth in this Subsection are not subject to the

Maximum included in Subsection EE, Durable Medical Equipment/Prostheses/Orthoses.

Equipment and supplies must be prescribed by a licensed Provider and are subject to applicable Deductibles and Coinsurance. Equipment and supplies prescribed as a result of diabetes as set forth in this Subsection are not subject to the Maximum included in Durable Medical Equipment/Prostheses/Orthoses or Ostomy Supplies of the Description of Covered Services Section of the Agreement.

If the Participant's coverage includes Prescription Drug coverage, the Participant pays the applicable Copayment directly to the Pharmacy for each Prescription. If the Plan does not have Prescription Drug coverage provided, there is a **$0 Tier 0**, **$10 Tier 1**, **$25 Tier 2**, and **$45 Tier 3** or as stated on ***the Outline of Coverage***. Prescription Drug Copayment payable by the Participant directly to the Participating Pharmacy for each Prescription; there is a **$0 Tier 0**, **$20 Tier 1**, **$55 Tier 2**, and **$135 Tier 3** or as stated on ***the Outline of Coverage*** mail order Prescription Drug Copayment payable by the Participant directly to the Participating Mail Order Pharmacy Provider.

The Covered Services provided for equipment and supplies, pharmacological agents and Orthoses for the treatment of diabetes are only available under the Agreement when the Participant is not enrolled for Prescription Drug coverage through another Prescription Drug program.

Y.BLOOD AND BLOOD PLASMA

Covered Services will be provided for whole blood, blood plasma, the administration of blood and blood processing, and blood derivatives, which are not classified as drugs by the U.S Food and Drug Administration ("FDA").

Z.AMBULANCE SERVICES

Covered Services are payable for Medically Necessary ambulance services by land, air or water, Advanced Life Support (ALS) or Basic Life Support (BLS) for local transportation. The ambulance must be transporting the Participant:

1. from home or from the scene of an accident or Medical Emergency, to the nearest Hospital;
2. between Hospitals;
3. between a Hospital and Skilled Nursing Facility;
4. from a Hospital or Skilled Nursing Facility to the Participant's home;
5. from the Participant's home or from a Facility Provider to an Outpatient treatment site; or
6. from an Outpatient treatment site to the nearest Hospital.

If there is no facility in the local area that can provide Covered Services for the Participant's condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service. If the Participant chooses to go to another facility that is farther away, payment will be based on the Allowable Charge for transportation to the closest facility that can provide the necessary services.

AA. PREVENTIVE CARE

Coverage will be provided for the preventive care services provided for in the Patient Protection and Affordable Care Act. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive care services include, but are not limited to the following:

1. Immunizations

Coverage will be provided for those pediatric immunizations, including 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 available until the Participant attains age twenty-one (21). Pediatric immunizations which are provided by a Preferred Provider are exempt from Deductibles, Copayments, and Coinsurance.

Covered Services are also provided for other immunizations, including immunizing agents, which are determined to be Medically Necessary.

2. Routine Gynecological Examinations and Pap Smears

Female Participants are covered for one (1) gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine Pap smear per Benefit Period. Covered Services which are provided by a Preferred Provider are exempt from Deductibles, Copayments, and Coinsurance.

3. Screening Mammograms

Screening mammograms are covered for all Participants whether or not directed toward a definite condition of disease or injury. Covered Services which are provided by a Preferred Provider are exempt from all Deductibles, Copayments and Coinsurance.

4. Colorectal Cancer Screening

Coverage for colorectal cancer screening is provided for covered individuals. Coverage for non-symptomatic covered individuals shall include, but is not limited to:

i. One (1) fecal occult blood test per Benefit Period.

ii. Sigmoidoscopy, screening barium enema, colonoscopy, or a test consistent with approved medical standards and practices to detect colon cancer, at a frequency determined by the covered individuals Physician.

Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.

Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles, payments and Coinsurance, when provided by a Preferred Provider.

5. Prostate Cancer Screening

Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal exam per Benefit Period. Covered Services are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Preferred Provider.

6. Preventive Drugs

Covered Services are provided for those generic equivalent preventive drugs with a prescription, which as determined by the U.S. Preventive Services Task Force have a rating of A or B, in accordance with the Affordable Care Act of 2010. Generic equivalent preventive drugs with a prescription are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a participating pharmacy.

In order to receive Covered Services, the Participant must present the Prescription and First Priority Life Identification Card to a participating pharmacy and the claim must be filed by a participating pharmacy.

7. Nutritional Therapy

Nutritional therapy to promote a healthy diet is available to Participants, when provided by a licensed health care professional, up to the Maximum of six (6) visits per Participant per Benefit Period or as indicated on ***the Outline of Coverage***. Covered Services are exempt from all Deductibles, Coinsurance and Copayments, when provided by Preferred Providers.

Diabetes Outpatient self-management training and education as provided in the Description of Covered Service Section and Nutritional Therapy provided to a Homebound Participant under the Description of Covered Services Section are exempt from this Benefit Maximum.

Coverage for dependent children, who are covered under the Agreement, will be provided as follows:

- Dependent children, ages two (2) through twelve (12), when accompanied by a parent.
- Dependent children, ages thirteen (13) through seventeen (17), with parental consent.

No coverage is provided for dependent children under the age of two (2).

BB. ALLERGY EXTRACTS/INJECTIONS

Covered Services are provided for allergy extracts and antigen injections.

CC. CHIROPRACTIC MANIPULATIVE COVERED SERVICES

For Participants age thirteen (13) and above, Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum per Benefit Period as set forth in ***the Outline of Coverage***, if Medically Necessary. No coverage is provided for Participants under the age of thirteen (13).

DD. DURABLE MEDICAL EQUIPMENT/PROSTHESES/ORTHOSES

Covered Services are provided for durable medical equipment, prostheses, and orthoses when prescribed by a licensed health care professional. Except for initial and subsequent prosthetic devices to replace the removed breast or portion thereof, replacements are not included, other than as certified as Medically Necessary for children due to the normal growth process.

Instructions regarding appropriate use of the item are covered.

Covered Durable Medical Equipment includes, but is not limited to, the following:

a. hospital beds and related equipment (bed rails, mattresses);

b. equipment to increase mobility (walkers, wheelchairs);

c. commodes (elevated seats, portable bedside commodes);

d. breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);

e. therapeutic equipment;

f. apnea monitors;

g. Jobst pressure garments used in burn treatment; and

h. Unna boots and air casts.

Covered Prostheses and Orthoses include, but are not limited to, the following:

a. artificial limbs;

b. knee braces, not made of elastic or fabric support;

c. splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or “figure-8", finger, Pavlik harness and wrist);

d. immobilizers;

e. corrective shoes, shoe inserts and supports, and/or other foot Orthoses;

f. supportive back braces with metal stays;

g. dynasplints;

h. cryocuffs; and

i. Covered Services are not payable for dental appliances, wigs, or eyeglasses, except as specified in Section DB – Description of Covered Services, Paragraph D. Surgery.

EE. OSTOMY SUPPLIES

Covered Ostomy Supplies include and are limited to the following:

a. ostomy appliances and supplies specifically relating to an ostomy (colostomy, ileostomy, urostomy or tracheostomy) are limited to: collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

b. urinary catheters, both reusable or disposable, whether or not used in conjunction with an ostomy.

Ostomy Supplies are covered as specified in Section SB – Schedule of Covered Services for Covered Medical Expenses up to a maximum of **$1,000** per Insured per Benefit Period or as indicated in ***the Outline of Coverage***. Coverage is limited to supplies obtained from Preferred Providers.

FF. AUTISM SPECTRUM DISORDERS

The Outline of Coverage specifies Autism Spectrum Disorder coverage and how it applies. When Autism Spectrum Disorder coverage is applicable, refer to the following:

For Participants under twenty-one (21) years of age or as indicated on the ***Outline of Coverage***, coverage will be provided for the diagnostic assessment of Autism Spectrum Disorders and for the treatment of Autism Spectrum Disorders up to a Maximum benefit of **$36,000*** or as indicated on the ***Outline of Coverage*** per Participant per Benefit Period. Once the Benefit Period Maximum has been reached, no additional Covered Services are available under the agreement for the remainder of the Benefit Period for the diagnostic assessment and/or treatment of the Participant's Autism Spectrum Disorder. When a Provider renders Medical Care for treatment of a health condition unrelated to or distinguishable from the Participant's Autism Spectrum Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be applied toward this dollar Maximum.

No coverage is provided for Participants age twenty-one (21) and over or as indicated on the ***Outline of Coverage***.

Treatment of Autism Spectrum Disorders shall be identified in a Treatment Plan for ASD and shall include any of the following Medically Necessary services: Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care, and Therapeutic Care that is:

i. Prescribed, ordered or provided by a licensed Physician, licensed Physician Assistant, licensed Psychologist, licensed clinical Social Worker, or certified Registered Nurse Practitioner.

ii. Provided by an Autism Service Provider.

Provided by a person, entity or group that works under the direction of an Autism Service Provider.

The treatment plan should be developed by a physician or psychologist, following a comprehensive evaluation consistent with current recommendations of the American Academy of Pediatrics. The treatment plan may be reviewed once every six (6) months, subject to Blue Cross' utilization review requirements, including case management, concurrent review and other managed care provisions. A more or less frequent review can be agreed upon by Blue Cross and the physician or psychologist developing the treatment plan. The provider is responsible for maintaining a copy of the autism assessment and treatment plan, to be made available upon request.

* After December 31, 2011, the Pennsylvania Insurance Commissioner shall publish in the Pennsylvania Bulletin an adjustment to the Autism Spectrum Disorder Maximum, equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U), to be applicable to the following Calendar Year. The Autism Spectrum Disorder Maximum shall be adjusted effective January 1 of the following Calendar Year.

The ***Outline of Coverage*** specifies whether Prescription Drug coverage applies.

If the Participant's coverage includes Prescription Drug coverage, the Participant is responsible for the applicable Copayment, Coinsurance, and/or Deductible, if any, for each Prescription prescribed for the treatment of Autism Spectrum Disorder. The Copayment, Coinsurance, and/or Deductible, if any, are paid by the Participant directly to the Pharmacy for each Prescription. The Outline of Coverage specifies the Copayment, Coinsurance, and/or Deductible amounts.

GG. RETAIL CLINIC CARE

Covered Services are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient or as indicated on ***the Outline of Coverage***. Covered Services are provided for the examination, diagnosis, and treatment of common minor ailments.

HH. Experimental or Investigative Services

A Medical Director of First Priority Life shall determine whether the use of any treatment, procedure, Provider equipment, drug, device, or supply (each of which is hereafter called a "Service") is Experimental or Investigative (that is not supported by evidence-based medicine).

1. If, in making that determination, a Medical Director of First Priority Life finds that the service, for which a claim for covered services is made, is either, (1) the subject of a written investigational or research protocol used by the treating Provider or of a written investigational or research protocol of another Provider studying substantially the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental, Investigative, educational, or research; or (3) the subject of an on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative.

2. If, in making that determination, a Medical Director of First Priority Life finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then a Medical Director of First Priority Life may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:

a. the technology must have final approval from the appropriate governmental regulatory bodies;

b. the scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;

c. the technology must improve the net health outcome;

d. the technology must be as beneficial as any established alternatives; and

e. the improvement must be attainable outside the investigational settings.

PEER REVIEW MEDICAL LITERATURE means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledge experts inside or outside the editorial office in their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publications.

3. If, in making the determination, a Medical Director of First Priority Life finds that a drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is received; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the drug, device, supply, or equipment shall be deemed to be Experimental or Investigative.

BlueCare® Traditional

Administrative Services Agreement

Outline of Coverage

Company Name:	Northern Tier Insurance Consortium(NTIC Troy Area School District	Group Number(s):014431000, 014432000, 014433000	
Company Code:	200210	Dependent/Student Age Limit:	26/26 end of month
Effective Date:	7/1/2012	New Born Children:	31 days
Renewal Date:	7/1/2013	Full-time student leave of absence:	Covered
Date - Part II Benefit Schedule:	7/1/2012	Domestic Partners:	Not Covered
Outline of Coverage Revision Date:		Credit (initial benefit period only)	
Grandfathered Status	No	Claims Appeal Fiduciary	BCNEPA
		Benefit Period	Calendar Year

	Participant Responsibility	Limitations/Non-Standard	Benefit Change Date/ Non-standard
FACILITY SERVICES			
Deductible	None		
Inpatient Copayment	No Copay		
Inpatient hospital services, including maternity	0%	unlimited	
Skilled nursing care	0%	60 days per Benefit Period.	
Transplants	0%		
Non-contracting Provider Coinsurance	30%	Allowable Charge'	
Precertification Penalty (facility)	$500	Late Precertification to a Non-contracting provider.	
Other Services			
Artificial Insemination	0%	3 attempts per lifetime	
Autism Spectrum Disorder	0%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $36,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Elective Abortions	Not Covered		
Emergency Medical /Accident Care	0%		
Newborn children	0%		
Ambulance (contracting provider), emergency	0%		
Ambulance (contracting provider), non-emergency	0%		
Ambulance (non-contracting provider), emergency	0%		
Home Infusion Therapy	0%		
Home Health services	0%	unlimited visits	
Hospice Care	0%	180 day lifetime maximum	

	Participant Responsibility	Limitations/Non-Standard	Benefit Change Date/ Non-standard
Morbid Obesity	0%	Surgery and medically necessary panniculectomies for participants 18 years or older who has no prior medical history or bariatric surgery; 1 morbid obesity procedure and 1 panniculectomy covered per lifetime. $2,000 copay per procedure for medically necessary Gastric Bypass Procedures. $1,000 copay per procedure for medically necessary panniculectomies.	
Radiation and chemotherapy	0%		
Dialysis	0%		
Inpatient Rehabilitation	0%	45 days per benefit period.	
Outpatient Cardiac Rehabilitation	Not Covered		
Outpatient Pulmonary Rehabilitation	Not Covered		
Outpatient Respiratory Therapy	Not Covered		
Outpatient Diabetes Education	0%		
Therapeutic Drugs which are not self-administered	0%		
Mental Health/ Substance Abuse			
Inpatient mental health services	0%	Unlimited inpatient.	
Inpatient Non-hospital residential substance abuse treatment	0%	Unlimited days.	
Substance Abuse Detoxification	0%	Unlimited days.	
Outpatient substance Abuse services	0%	Unlimited visits.	
Outpatient emergency room visit	0%		
Ambulance (contracting provider), emergency	0%		
Ambulance (contracting provider), non-emergency	0%		
Ambulance (non-contracting provider), emergency	0%	Participants may be liable for charges that exceed the allowable charge.	
PROFESSIONAL SERVICES			
Deductible	None		
Non-contracting Provider Coinsurance	30%	Allowable Charge'	
Inpatient Physician Visits	0%	unlimited	
Autism Spectrum Disorder	0%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $36,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Allergy testing	0%		
Maternity	0%		
Newborn children	0%		
Bony Impacted Wisdom Teeth	50%	In-network coverage only.	
Chemotherapy	0%		
Cosmetic	Not Covered		
Outpatient Diabetic Education	0%		
Diagnostic Medical	0%		
Diagnostic Pathology	0%		
Dialysis	0%		

	Participant Responsibility	Limitations/Non-Standard	Benefit Change Date/ Non-standard
Emergency Medical /Accident Care	0%		
Hearing	Not Covered		
Routine physical exams	0%	Routine exams are preventive medical evaluations and management exams.	7/1/2011
Outpatient Physical Therapy	Not Covered		
Outpatient Respiratory Therapy	Not Covered		
Psychiatric inpatient visits	0%		
Routine gynecological exam and pap smear	0%	One per benefit period.	
Childhood Immunizations	0%		
Routine Mammography/ diagnostic	0%		
Routine colorectal cancer and prostate cancer screening	0%		
Neonatal Circumcisions	0%		
Skilled nursing facility care	0%		
Second surgical opinion	0%	Limited to one (1) consultation per consultant.	
Surgery - Assistant Surgery	0%		
Therapeutic Drugs which are not self- administered	0%		
Infertility	0%	Diagnostic services leading up to the diagnosis of infertility.	
Invitro Fertilization	Not covered		
Artificial Insemination	0%	3 attempts per lifetime	
Voluntary Sterilization	0%		
MAJOR MEDICAL SERVICES			
Annual Deductible per person	$100	Per Benefit Period. Deductible must be met first prior to claim payment	
Annual Deductible per family	$300	Maximum 3 separate deductibles per family, per Benefit Period. Deductible must be met first prior to claim payment.	
Coinsurance	20%	Allowable Charge I	
Annual coinsurance maximum per person	total $2,000/ member $400	Per Benefit Period.	
Annual coinsurance maximum per family	total $6,000/ member $1,200	Maximum 3 separate coinsurance maximums per family, per Benefit Period.	
Lifetime Maximum	Unlimited		7/1/2011
Ambulance	Not Covered	Emergency/ Non-emergency	
Autism Spectrum Disorder	20%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $36,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Cardiac Rehabilitation	20%	36 visits per Benefit Period.	
Chiropractic manipulative benefits	20%	20 visits per Benefit Period, ages 13 and up. All services billed by a chiropractor are applied to the chiropractic benefit.	
Durable medical equipment, prosthetics, & orthotics	20%	Unlimited maximum	7/1/2011

	Participant Responsibility	Limitations/Non-Standard	Benefit Change Date/ Non-standard
Ostomy supplies	50%	Ostomy appliances and supplies specifically relating to an ostomy. Limited to collection devices, irrigation equipment and supplies, skin barriers and skin protectors; and urinary catheters, both re-usable or disposable, whether or not used in conjunction with an ostomy. Covered up to $1,000 maximum per participant per benefit period. Amounts are applied to coinsurance maximum but will always pay at coinsurance amount. In network only.	
Outpatient Dialysis	Not covered		
Home Infusion Therapy	Not covered		
Non-Contracting Provider Balances	Not covered		
Nutritional Therapy	0%	6 visits per member per benefit period. Not subject to deductible.	7/1/2011
Outpatient Physician sick office visits	20%	Sick visits must have diagnosis.	
Outpatient Occupational Therapy	20%	12 visits per Benefit Period.	
Outpatient Pulmonary Rehabilitation	20%	18 visit per benefit Period.	
Outpatient Respiratory Therapy	20%	18 visit per benefit Period.	
Outpatient Physical Therapy	20%	20 visit per benefit Period.	
Outpatient Speech Therapy	20%	12 visits per Benefit Period.	
Prescription Drugs	Not Covered		
Private Duty Nursing	Not Covered		
Therapeutic Drugs which are not self- administrable	Not Covered		
Outpatient Mental Health services	0%	Unlimited visits. Not subject to deductible.	
Private Room Allowance	Not Covered		
PRESCRIPTION DRUGS			
Deductible per person	None		
Deductible per family	None	Three individual deductibles must be met in order to satisfy the family deductible per benefit period.	
Maximum per person	None		
Maximum per family	None	Three individual maximum must be met in order to satisfy the family maximum per benefit period.	
Yearly maximum	None		
Lifetime maximum	None		
Formulary	Multi-tier		
Retail	Covered	30-day supply.	
Tier 0	Not Covered		
Tier 1	$12		
Tier 2	$20		
Tier 3	$20		
Specialty Drugs (Tier 5)	Not Covered	Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of $3,000 per participant per Benefit Period.	
Mail Order	Covered	Up to a 90-day supply.	
Tier 0	Not Covered		

	Participant Responsibility	Limitations/Non-Standard	Benefit Change Date/ Non-standard
Tier 1	$24		
Tier 2	$40		
Tier 3	$60		
Contraceptives	Covered	Excluding devices	
Exclusive Home Delivery	No	One original fill plus one refill available at the retail pharmacy.	
Select Home Delivery	Yes	Participants are required to make a choice about their maintenance prescription drugs. Participants will have 2 fills at the retail pharmacy and then be required to contact Express Scripts with a decision on their third fill to continue through the retail pharmacy or switch to a mail order program.	
Mandatory Generic	Yes	Participant is responsible for the difference in cost between the brand name and generic drug if member or physician selects a brand name drug when there is a generic drug available.	
Quantity Limits	Yes	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Yes	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Metabolic Supplement	Yes	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Yes	The program requires the use of a first step drug(s) before use of a 2nd or 3rd step drug.	
Prior Authorization	Yes	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Vaccine Program	Yes	Vaccines are provided and administered by pharmacists contracted to administer vaccines.	
Weight Loss Drugs	Not Covered		
Exclusions	Please see attached		

Part II Administrative Services Agreement Benefit Schedule is the Covered Service descriptions and will apply as stated, unless otherwise indicated on Part I Outline of Coverage.

' The allowable charge is established by a provider agreement or is the billed amount, whichever is less, and will be accepted by the contracting provider as p for covered services less any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums. For a non-contracting provider, they allow the same amount First Priority Life would pay to a contracting provider. Non-contracting providers may balance bill the participant.

* Coverage described in this column applies when services are performed by Participating Providers, or are otherwise in accordance with network rules. Non-contracting providers will reduce to the coinsurance indicated for all facility charges.

The Plan will follow First Priority Life precertification guidelines. Unless otherwise indicated, the Plan will follow First Priority Life Medical Policy.

Indemnity
Standard Exclusions

This amends the Administrative Service Agreement Indemnity as follows:

The EXCLUSIONS section is amended by adding the Standard Exclusions as indicated below:

A. Except as may be specifically provided in the Covered Services, the following are not covered under the Agreement:

1. Services which are not Medically Necessary, except those that are provided within the Agreement for preventive services or those mandated by law.
2. Any service in connection with or required by a procedure not set forth in the foregoing Description of Covered Service Section, except as necessitated by subsequent complications.
3. Services in excess of any Benefit Maximum as stated in Section DB — Description of Covered Services
4. Charges for services or supplies incurred prior to the Participant's Effective Date.
5. Covered Services After Termination of Coverage, charges for services or supplies incurred after the date of termination of the Participant's coverage.
6. Charges, which exceed the Allowable Charge.
7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.
8. Services which First Priority Life initially determines are Experimental or Investigative; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative.
9. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation; or losses sustained or expenses incurred as a result of act of war whether declared or undeclared.
10. Treatment or services received as a result of the Participant's participation in a riot or insurrection.
11. Services as a result of injuries sustained during the Participant's commission of or attempt to commit a felony.
12. Services for which a Participant would have no legal obligation to pay.
13. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from Surgery.
14. The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy; otoplasty; rhytidectomy; blepharoplasty; actinic changes; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following Surgery for breast disease; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.
15. Treatment of temporomandibular joint (TMJ) or myofascial (MPD) pain dysfunction or craniomandibular (CMD) pain syndrome, including surgical and non- surgical exam, invasive and non- invasive procedures and tests, and all related medical and surgical services. Examples of non-Covered Services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.
16. With respect to the extraction of partially or totally bony impacted wisdom teeth:
    a. Hospital and Ambulatory Surgical Facility services are not covered, except if authorized by a Medical Director of First Priority Life as set forth in Section DB — Description of Benefits, Subsection D, Surgery, Paragraph 3.
    b. General anesthesia charges are not covered, except as indicated in Section DB — Description of Covered Services, Subsection D, Surgery, Paragraph 3.
    c. With respect to all other dental procedures and oral Surgery, the following are excluded:
    d. Removal of natural teeth, except when removal of teeth is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations
    e. All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injury to the jaws, natural teeth, mouth or face. Chewing or biting shall not be considered an accidental injury
    f. Dental appliances, including, but not limited to dentures and bridges, except for the primary restoration following facial/dental

trauma or when an integral part of a cleft palate repair.

i. Dental implants

ii. Treatment of diseases of the teeth or gums, including but not limited to treatment of dental cavities.

iii. Periodontics, endodontics, and orthognathic Surgery.

iv. Orthodontics, except orthodontic treatment related to cleft palate repair as described in Section DB — Description of CoveredServices, Subsection D, Surgery, Paragraph 1.

v. Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.

vi. Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures unless such procedureswere for the treatment of accidental bodily injury.

17. Charges to the extent payment has been made under Medicare or when Medicare is the primary carrier, or under another governmental program, except Medicaid.

18. Charges to the extent payment has been made under a state or federal workers' compensation, employer's liability or occupational disease law, or local government program.

19. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational DiseaseLaw or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims coveredby a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law or anyapplicable federal or state law. This exclusion applies regardless of whether the Participants claims the benefit compensation.

20. Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD underthe Agreement and for Participants age twenty-one (21) and over.

    a. Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in SectionDB — Description of Covered Services.

    b. Treatment of Autism Spectrum Disorder through the use of Chelation Therapy.

    c. Any services listed in an Individual Education Plan (IEP) are not covered.

21. Services for the treatment of anti-social personality, conduct disorders and paraphilias.

22. Substance Abuse services utilizing methadone or methadone-like equivalents.

23. Biofeedback/neurofeedback.

24. Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cordblood collection, preparation or storage.

25. Routine and cosmetic foot care, except for care provided as certified Medically Necessary for children due to the growth processor for care provided as a result of diabetes.

26. The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes.

27. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or workhardening programs.

28. Custodial care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.

29. Physical, psychiatric or psychological examinations, testing, reports, or treatments, when such services are: (a.) for purposes ofobtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage oradoption; (b.) relating to judicial or administrative proceedings or orders; (c.) conducted for purposes of medical research; or (d.)to obtain or maintain a license of any type.

30. Services and associated expenses related to the non-surgical, medical treatment of obesity, including but not limited to, dietarysupplements or programs for weight reduction.

31. Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except thosedrugs that are mandated to be covered by law and/or that provide at least thirty-five (35) percent of daily caloric requirementsgiven enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take nutrition by mouth, or inconditions of gastrointestinal tract impairment, parenterally through an intravenous catheter.

32. Infant formulas including those prescribed for reasons of fat malabsorption, lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic Formulas, except those that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
33. The purchase of organs, which are sold rather than donated to transplant recipients, and charges for organ donor searches are also excluded from coverage.
34. Long-Term Residential Care.
35. Outpatient cognitive rehabilitation services which have been determined by First Priority Life not to be Medically Necessary and appropriate for the treatment of brain injury.
36. Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.
37. Pulmonary Rehabilitative Therapy on an Inpatient basis.
38. Reversal of voluntary sterilization.
39. Transsexual Surgery and treatment and services in support of transsexual surgery, except for treatment resulting from a complication of such transsexual Surgery.
40. Charges in connection with penile implants.
41. Abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.
42. Separate charges by interns, residents, and other health care professionals who do not have a Provider Agreement with First Priority Life, who are directly, or indirectly employed by a Hospital or Facility Other Provider which makes their services available.
43. Corneal Surgery to change the shape of the cornea to correct vision problems, except for accidental injury or Medically Necessary conditions resulting from corneal Surgery.
44. Routine eye examinations; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.
45. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to allergen filtration systems, including allergy products.
46. Charges for telephone calls or telephone consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.
47. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.
48. Assisted fertilization techniques such as, but not limited to, In Vitro Fertilization (IVF), of any kind including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment, embryo acquisition, storage and transport, human chorionotropin, urofollitropin, menatropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.
49. Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise determined by First Priority Life to be non-standard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, or prosthetic socks, except when administered by a home health agency as part of the home health benefit or as provided in Section DB — Description of Covered Services, Subsection X, Diabetes Education/Equipment/Supplies or Subsection FF, Ostomy Supplies; (d) exercise equipment; (e) self help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or piece of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) or intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in Section DB — Description of Covered Services, Subsection D, Surgery; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) proglide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; and (v) modification or customization of any Durable Medical Equipment.
50. Examinations for the prescription, fitting or adjustment of hearing aids.
51. Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in Section DB — Description of Covered Services, Subsection Z, Ambulance Services.
52. Services performed by a Provider with the same legal residence as a Participant or who is a family member, including spouse, brother, sister, parent or child.
53. Services of Immediate Family or persons of the Participant's household.
54. Alternative and complementary medicine, except as provided in Section CC — Care Coordination, Subsection I, Case Management.
55. Adult circumcision in the absence of disease.
56. Charges for a private room when a Semi-Private Room is available.

57. Services, which are not prescribed, performed or directed by a Provider licensed to do so.

58. Educational classes, support groups and disease management programs unless sponsored or provided by First Priority Life orrequired for diabetes education services and those that are mandated to be covered by law.

59. Unattended Services.

60. Take-home drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider;injectable or implantable contraceptive drugs and devices that are not self-administrable (except when used for an approvedmedical condition other than contraception) and fertility drugs regardless of use; drugs in certain drug classes specificallydesignated by First Priority Life as Specialty Drugs including, but not limited to: self-administrable injectables, such asantihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives unless provided in connection with covered transplants, monoclonal antibodies, andother biotech drugs; except those drugs administered by a Preferred Professional Provider that are not self-administrable and/orthat are provided incident to a Covered Service; those drugs that are mandated to be covered by law; and/or which are coveredunder Section Rx — Prescription Drug Coverage, when coverage is provided for Prescription Drugs. (The Outline of Coverage.

61. Copayments, Deductibles, Coinsurance or penalties applied under the Plan.

WELCOME TO THE INDEMNITY PROGRAM

This Benefit Schedule is a summary of the covered services and main features of the indemnity health benefits program.

Please reference the Summary Plan Description carefully to determine which health care services are covered.

However, the Participant agrees that any person or organization furnishing services or supplies to him is authorized to provide Blue Cross and/or Blue Shield with requested information and records.

DEFINITIONS

The following words and phrases when used in the Benefit Schedule shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. **ADJUNCTIVE PROCEDURES** – Physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization performed by an individual holding the appropriate licensure and certification.

2. **ALCOHOL AND/OR DRUG ABUSE** – Any use of alcohol or other drugs 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. For the purposes of the Benefit Schedule, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).

3. **ALLOWABLE CHARGE** – In the case of a Contracting Professional Provider, the Allowable Charge is established by a Provider Agreement or is the billed amount, whichever is less, and will be accepted by the Contracting Professional Provider as payment in full for Covered Services. The Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

   In the case of a Non-Contracting Professional Provider, the Allowable Charge is the same amount First Priority Life would pay to a Contracting Professional Provider, or is the billed amount, whichever is less, with the exception of Outpatient Emergency Services[1] . The Participant is liable for charges that exceed the Allowable Charge in addition to any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

   For Outpatient Emergency Services[1], the Allowable Charge is a amount equal to the greatest of the following three possible amounts (1) The amount First Priority Life would pay to a Contracting Professional Provider for Outpatient Emergency Services; (2) The amount First Priority Life would pay to a Non-

[1] In the event that the Participant received Outpatient Emergency Services by a Non-Contracting Provider, First Priority Life will provide coverage at the Contracting Provider level and the Participant's Out-Of-Pocket expenses will be no greater than the amount that would have been incurred if a Contracting Provider had been used.

Contracting Professional Provider for Outpatient Emergency Services; or (3) The amount that would have been paid under Medicare for Outpatient Emergency Services.

In the case of a Contracting Facility Provider, the Allowable Charge is established by a Provider Agreement and will be accepted by the Contracting Facility Provider as payment in full for Covered Services. The Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Contracting Facility Provider, the Allowable Charge is the average amount First Priority Life would pay to a Contracting Facility Provider. With the exception of Outpatient Emergency Services[1], the Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

For Outpatient Emergency Services[1], the Allowable Charge is a amount equal to the greatest of the following three possible amounts (1) The amount First Priority Life would pay to a Contracting Facility Provider for Outpatient Emergency Services; (2) The amount First Priority Life would pay to a Non- Contracting Facility Provider for Outpatient Emergency Services; or (3) The amount that would have been paid under Medicare for Outpatient Emergency Services.

Participants may contact BlueCare Service Representatives toll-free at 1-800-829-8599 weekdays during normal business hours for a determination of Covered Services. Hearing impaired persons can call (TDD) 1-866-280-0486. Participants may also write to:

First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711

4. **ALTERNATIVE TREATMENT PLAN** – A voluntary program whereby the Participant is offered cost- effective treatment alternatives in lieu of the stated Covered Services in the Benefit Schedule, without compromising the quality of care. First Priority Life's Care Management Department, in cooperation with the Physician, organizes and coordinates care through multi-disciplinary resources.

5. **AMBULATORY SURGICAL FACILITY** – A Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, by the Accreditation Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to First Priority Life which:

   a. has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;

   b. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the facility;

   c. does not provide Inpatient accommodations; and

   d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

6. **APPLIED BEHAVIORAL ANALYSIS** – 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.

7. **AUTISM SERVICE PROVIDER** – A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in Pennsylvania. Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth's medical assistance program on or before the effective date of this section.

8. **AUTISM SPECTRUM DISORDER (ASD)** – 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 disorders not otherwise specified.

9. **BEHAVIOR SPECIALIST** – An individual who designs, implements or evaluates a behavior modification intervention component of a Treatment Plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

10. **BEHAVIORAL HEALTH ACUTE CARE** – Health care delivered to an Insured, experiencing an acute illness or trauma, consisting of high level skilled psychiatric or Substance Abuse services within a freestanding psychiatric hospital, a psychiatric unit of a general hospital or a detoxification unit within a Hospital setting.

11. **BENEFIT PERIOD** – A Calendar Year or a Benefit Year. (Refer to the Outline of Coverage for the period selected by the Plan.)

12. **BENEFIT YEAR** – A period of twelve (12) consecutive months beginning with the Effective Date of the Plan during which charges for Covered Services must be incurred in order to be eligible for payment by First Priority Life. A charge shall be considered incurred on the date the service or supply was provided to a Participant. ***(Refer to the Outline of Coverage for the period selected by the Plan.)***

13. **BUSINESS DAY –** A day that First Priority Life is open for business.

14. **CALENDAR YEAR** – A one-year period which begins on January 1 and ends on December 31. ***(Refer to the Outline of Coverage for the period selected by the Plan.)***

15. **CHEMOTHERAPY** – The treatment of disease by chemical or biological therapeutic agents.

16. **CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)** – A form of manual treatment to influence joint and neurophysiological function or the use of Adjunctive Procedures in treating misaligned and displaced vertebrae or articulation and related conditions of the nervous system provided by an individual holding the appropriate licensure and/or certification.

17. **COINSURANCE** – Coinsurance applies to major medical Covered Services and to services rendered by Non-Contracting Providers. A specific percentage amount of the Allowable Charge, set forth in ***the Outline of Coverage***, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

18. **COINSURANCE MAXIMUM** – A specified dollar amount of Coinsurance that applies to major medical Covered Services incurred by a Participant, as set forth in ***the Outline of Coverage***, for Covered Services in a Benefit Period. ***(Refer to the Outline of Coverage for the period selected by the Plan.)*** The Coinsurance Maximum does not include Deductibles, amounts in excess of the Allowable Charge, charges for non-Covered Services, and charges after the Plans Covered Service limits for Covered Services have been exhausted.

19. **COMMUNITY BEHAVIORAL HEALTHCARE NETWORK OF PENNSYLVANIA (CBHNP)** – First Priority Life's dedicated unit that provides eligibility verification, triage, referral and utilization management for mental health-chemical recovery (behavioral health) services.

20. **COPAYMENT** – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth in the Benefit Schedule and in ***the Outline of Coverage***.

21. **COSMETIC PROCEDURE** – A medical or surgical procedure which is primarily performed to improve the appearance of any portion of the body.

22. **COVERED SERVICE** – All Medically Necessary Provider services and supplies which are administered by First Priority Life under the terms of this Agreement.

23. **CUSTODIAL CARE** – Services to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of skilled, trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential, or place of service.

24. **DEDUCTIBLE** – A specified amount of Covered Services, as set forth in ***the Outline of Coverage***, expressed in dollars that must be incurred by a Participant before First Priority Life will assume any liability for all or part of the remaining covered major medical or Professional Provider expenses.

25. **DEPENDENT** - The spouse of a Participant; or the Participant's or the Participant's spouse's child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.

26. DETOXIFICATION – The process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol, drug or other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

27. DIAGNOSTIC ASSESSMENT OF ASD – Medically necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician Assistant, licensed Psychologist or Certified Registered Nurse Practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

28. DIAGNOSTIC SERVICES – The following procedures ordered by a Physician because of specific symptoms to and sign to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in Description of Covered Services and include, but are not limited to:

a. diagnostic imaging;

b. diagnostic pathology, consisting of laboratory and pathology tests;

c. diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life; and

d. allergy testing consisting of percutaneous, intracutaneous and patch tests.

29. DURABLE MEDICAL EQUIPMENT – Equipment which:

a. can withstand repeated use; and

b. is primarily and customarily used to serve a medical purpose; and

c. generally is not useful to a person in the absence of an illness or injury; and

d. is appropriate for use in the home.

30. ELIGIBLE PERSON – A person entitled to be a Participant as specified in the Schedule of Eligibility.

31. EMERGENCY MEDICAL CONDITION – means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867 (e)(1)(A) of the Social Security Act.

32. EMERGENCY SERVICE – means (i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

33. EXPERIMENTAL OR INVESTIGATIVE – The use of any treatment, procedure, facility, equipment, drug, device or supply that is determined to be not supported by evidence-based medicine and therefore:

a. Not accepted by the general medical community as standard medical treatment of the condition being treated or does not have definitive outcome studies in peer-reviewed medical literature demonstrating safety and efficacy for treating or diagnosing the condition or illness for which its use is proposed and/or lacks studies comparing outcomes to existing approved modalities of therapy or diagnosis; or

b. Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information for the Health Care Professional as appropriate for the proposed use at the time services were rendered; or

c. Subject to review and approval by any institutional review board for the proposed use; or

d. The subject of an ongoing clinical trial that meets the definition of a phase I or II clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

34. FACILITY OTHER PROVIDER – An institution or entity, other than a Hospital, that is licensed, where required, to render Covered Services.

35. FACILITY PROVIDER – A Hospital or Facility Other Provider, licensed where required, to render Covered Services.

36. FREESTANDING DIALYSIS FACILITY – A Facility Other Provider, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home-care basis.

37. FREESTANDING OUTPATIENT FACILITY – A Facility Other Provider, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.

38. FULL-TIME STUDENT – An individual who is enrolled in a recognized college or university carrying a minimum of twelve (12) undergraduate credits or nine (9) graduate credits per semester, or enrolled full- time in a trade or secondary school.

39. HIPAA – The federal Health Insurance Portability and Accountability Act of 1996.

40. HOMEBOUND – A Participant will be considered homebound if he/she has a condition due to an illness or injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated. The condition of these Participants should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.

41. HOME HEALTH CARE AGENCY – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license:

a. provides skilled Outpatient services on a visiting basis in the Participant's home; and

b. is responsible for supervising the delivery of such services under a plan authorized by the Physician.

42. HOME INFUSION THERAPY – The preparation and administration of parenteral and enteral nutrition and/or intravenous solutions and drugs, which are provided in the home or infusion center setting.

43. HOME INFUSION THERAPY AGENCY – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life; is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license; provides Home Infusion Therapy services in the Participant’s home or an infusion center; and is responsible for supervising the delivery of such services under a plan authorized by the Physician.

44. HOSPICE – A Facility Other Provider, which is primarily engaged in providing supportive care to terminally ill individuals.

45. HOSPICE CARE – A health care program which provides an integrated set of services, primarily in the patient’s home, designed to provide supportive care intended to promote comfort to and relieve suffering of terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the Participant’s Physician.

46. HOSPITAL – A Provider that is a short-term, acute care or Rehabilitation Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Hospital Association, the Pennsylvania Department of Health, or a similar accrediting agency acceptable to First Priority Life, or a Provider that is a state-owned Psychiatric Hospital, and which:

a. is a duly licensed institution;

b. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;

c. has organized departments of medicine and/or major Surgery;

d. provides 24-hour nursing service by or under the supervision of Registered Nurses; and

e. is not, other than incidentally, a:

a. Skilled Nursing Facility

b. nursing home
c. Custodial Care home
d. health resort
e. spa or sanitarium
f. place for rest
g. place for the aged
h. place for the provision of Hospice Care, or
i. personal care home.

47. HOST PLAN – The on-site Blue Cross/ Blue Shield Plan, which services the geographic area outside the Service Area where the Covered Services are provided.

48. IDENTIFICATION CARD/CARD CARRIER – The currently effective card/card carrier issued to the Participant and Dependents by First Priority Life.

49. IMMEDIATE FAMILY – The Participant's spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

50. INDIVIDUAL EDUCATION PLAN (IEP) – A plan for school-based services.

51. INPATIENT – A Participant who is treated as a registered bed patient in a Hospital or Facility Other Provider, who is expected to stay overnight and for whom a room and board charge is made.

52. INPATIENT MENTAL HEALTH HOSPITAL – A short-term acute care Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association, or a similar accrediting agency acceptable by First Priority Life and which provides services that are necessary for short-term evaluation, diagnosis, and treatment (or crisis intervention) of Serious Mental Illness.

53. INPATIENT NON-HOSPITAL RESIDENTIAL CARE – The provision of medical, nursing, counseling, or therapeutic services to patients suffering from Alcohol and/or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

54. INPATIENT NON-HOSPITAL RESIDENTIAL FACILITY – A Facility Other Provider licensed by the Pennsylvania Department of Health to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care. (This is not a half-way house or group home.)

55. LICENSED PRACTICAL NURSE (LPN) – A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

56. LONG-TERM RESIDENTIAL CARE – The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day to day activities and responsibilities) to patients suffering from Alcohol and/or Drug Abuse or dependency. This care is provided in a long-term residential environment known as a Transitional Living Facility, on an individual, group, and/or family basis, with a program duration greater than sixty (60) days. Long-Term Residential Care is not Inpatient Non-Hospital Residential Care.

57. MASTECTOMY – Removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

58. MAXIMUM – The greatest Covered Service amount payable by First Priority Life. This could be expressed in dollars, number of days, or number of services for a specified period of time.

a. BENEFIT MAXIMUM – The greatest Covered Service amount payable by First Priority Life for a specific Covered Service.

b. LIFETIME BENEFIT MAXIMUM – The greatest Covered Service amount payable by First Priority Life in the Participant's lifetime set forth in ***the Outline of Coverage***.

59. MEDICAL CARE/MEDICAL SERVICES – Services rendered by a Professional Provider intended to prevent illness (routine preventive care) and/or restore health (treatment of an illness or injury).

60. MEDICALLY NECESSARY or MEDICAL NECESSITY – Services or supplies rendered by a Provider that First Priority Life determines are:

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

b. provided for the diagnosis, or the direct care and treatment of the Participant's condition, illness, disease or injury;

c. in accordance with current standards of medical practice;

d. not primarily for the convenience of the Participant, or the Participant's Provider; and

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

61. MEDICARE – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

62. MENTAL OR NERVOUS DISORDER – Mental, nervous, or emotional disorder means a neurosis, psychoneurosis, psychopathy, or psychosis.

63. METABOLIC FORMULAS – Special nutritional formulas administered under the direction of a Physician, which are necessary to sustain life for a genetic metabolic disorder.

64. MORBID OBESITY – The term refers to patients who have a body mass index (BMI) of 40 or greater.

65. NUTRITIONAL THERAPY – Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a licensed health care professional to help a person make and maintain healthy dietary changes.

66. ORTHOSIS – A rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

67. OSTOMY – An artificial stoma or opening into the urinary tract, gastrointestinal canal or the trachea.

68. OSTOMY SUPPLIES – Generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advice of a healthcare Provider.

69. OUTPATIENT – A Participant who receives services or supplies while not an Inpatient.

70. OUT-OF-POCKET – A dollar amount paid by the Participant which includes Deductible, Coinsurance and Copayment amounts. It does not include penalties for failure to obtain Pre-Certification, premiums, amounts in excess of the Allowable Charge, charges for non-Covered Services, and charges after Covered Services have been exhausted.

71. PARTIAL HOSPITALIZATION PSYCHIATRIC CARE SERVICES – The provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.

72. PARTIAL HOSPITALIZATION SUBSTANCE ABUSE SERVICES – The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-hospital facility licensed by the Department of Health to provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient care.

73. PHARMACY CARE – 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.

74. PHYSICIAN – A person, who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and prescribe and administer drugs.

75. PRE-CERTIFICATION – The process whereby a Provider or a Participant, as applicable, is required to obtain certification from First Priority Life for Covered Services prior to the date of service. Pre-Certification will result in the issuance of a Pre-Certification number or approval by First Priority Life, without which the claim may not be paid. First Priority Life may add or delete services, which require Pre-Certification, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan at the address on the records of First Priority Life at least thirty (30) days in advance of such change.

76. PRIVATE DUTY NURSING – Total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.

77. PROFESSIONAL PROVIDER – An individual or practitioner, who is licensed/certified to render Covered Services. Professional Providers include, but are not limited to:

Certified Addiction Counselor	Occupational Therapist
Chiropractor	Optometrist
Clinical Psychologist	Physical Therapist
Clinical Nurse Specialist	Physician
Dentist	Physician Assistant
Licensed Dietitian	Podiatrist
Licensed Practical Nurse	Registered Nurse
Nurse Midwife	Social Worker
Nurse Practitioner	Speech Therapist

78. PROSTHESIS – An artificial body part, which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.

79. PROVIDER – A Facility Provider, Professional Provider, Pharmacy Provider, or Supplier licensed, where required, and performing services within the scope of such license

a. **CONTRACTING PROVIDER (Contracting Professional Provider/Contracting Facility Provider)** – A Provider who signed a Provider Agreement with First Priority Life and/or is a member of the BlueCard PAR Network.

b. **NON-CONTRACTING PROVIDER (Non-Contracting Professional Provider/Non-Contracting Facility Provider)** – A Provider who has not signed a Provider Agreement with First Priority Life and/or who is not a member of the BlueCard PAR Network.

80. PROVIDER AGREEMENT – An agreement between a Provider and First Priority Life or any other Blue Plan (Host Blue) participating in BlueCard pursuant to which negotiated rates are established on a contracting provider basis for payment of Covered Services rendered to a Participant.

81. PSYCHIATRIC CARE – Direct or consultative service provided by a Physician who specializes in psychiatry.

82. PSYCHIATRIC HOSPITAL – A Facility Provider, approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

83. PSYCHOLOGICAL CARE – Direct or consultative services provided by a Psychologist.

84. PSYCHOLOGIST – A licensed clinical Psychologist.

85. RECONSTRUCTIVE PROCEDURE/SURGERY – Procedures, including surgical procedures, performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from disease, accidental injury, or a previous therapeutic process. This includes a surgical procedure performed on one breast or both breasts following a Mastectomy, as determined by the treating Physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the Mastectomy and it includes, but is not limited to: augmentation mammoplasty, reduction mammoplasty and mastopexy.

86. REGISTERED NURSE (RN) – A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

87. REHABILITATIVE CARE – Professional services and treatment programs, including applied behavioral analysis,

provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

88. **REHABILITATION HOSPITAL** – A Facility Provider approved by the appropriate accrediting agency or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

89. **RESPITE CARE** – Residential Medical given in a setting outside the patient's home, such as in a Skilled Nursing Facility, in order to provide a brief interval of relief for the patient's primary caregiver, which is usually a family member.

90. **RETAIL CLINIC CARE –** The treatment of common minor ailments (in a health care facility located in a convenient setting, such as a retail store, grocery store or pharmacy, which offers unscheduled, walk-in care) including, but not limited to, sore throat, coughs or pink eye.

91. **SEMI-PRIVATE ROOM** – The bed, board and nursing care regularly provided to patients in a room which is designated as semi-private by the Provider of care and which contains more than one bed.

92. **SERIOUS MENTAL ILLNESS** – Any of the following mental illnesses, as defined by the American Psychiatric Association; schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

93. **SERVICE AREA** – The following thirteen (13) Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

94. **SKILLED NURSING FACILITY** – A Facility Other Provider, which is an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental disorders, alcoholism or drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested.

95. **SUBSTANCE ABUSE** – 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.

96. **SUBSTANCE ABUSE TREATMENT FACILITY** – A licensed Facility Provider, which is primarily engaged in Detoxification and/or rehabilitation treatment for Alcohol and/or Drug Abuse. The Facility Provider must meet the minimum standards for such facilities set by the Pennsylvania Department of Health.

97. **SUPPLIER** – An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.

98. **SURGERY** – The performance of generally accepted operative and cutting procedures, including specialized instrumentations, endoscopic examinations and other procedures; the correction of fractures and dislocations; and usual and related pre-operative and post-operative care.

99. **THERAPEUTIC CARE** – Services provided by Speech Language Pathologists, Occupational Therapists or Physical Therapists.

100. **THERAPY SERVICE** – Services or supplies used for the treatment of an illness or injury to promote the recovery of a Participant. Therapy Services are covered to the extent specified in the Benefit Schedule.

a. CARDIAC REHABILITATION THERAPY – An exercise program, which is effective in the physiological and psychological rehabilitation of patients with cardiac conditions.

b. COGNITIVE REHABILITATION THERAPY – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain injury.

c. DIALYSIS TREATMENT – The treatment of acute renal failure or chronic irreversible renal insufficiency or

removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

d. OCCUPATIONAL THERAPY – The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

e. PHYSICAL THERAPY – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part performed by a licensed Physical Therapist.

f. PULMONARY REHABILITATION THERAPY – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders.

g. RADIATION THERAPY – The treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

h. RESPIRATORY THERAPY – The introduction of dry or moist gases into the lungs for treatment purposes.

i. SPEECH THERAPY – The treatment for the correction of a speech impairment resulting from disease, Surgery, injury, anomalies or previous therapeutic processes

101. TREATMENT PLAN FOR ASD – A plan for the treatment of Autism Spectrum Disorders 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.

102. UNATTENDED SERVICES – Services that are not accompanied by a Provider or monitored by a Provider.

103. URGENT CARE – The provision of immediate medical service offering outpatient care (in a facility dedicated to the delivery of unscheduled, walk-in care outside of a hospital emergency department) for the treatment of acute and chronic illness or injury.

CARE COORDINATION

Subject to the exclusions, conditions, and limitations of the Benefit Schedule, a Participant is entitled to Covered Services under the Agreement, provided that components of the care coordination plan are followed. Covered Services and payment allowances are described in ***the Outline of Coverage***.

A. SELECTION OF PROVIDERS

A Participant covered under the Plan has the option of choosing where and to whom to go for Covered Services.

Covered Services may be rendered by a Contracting Provider or a Non-Contracting Provider. Most Covered Services are paid at a higher reimbursement level when performed by Contracting Providers.

B. EMERGENCY SERVICES

In the event that the Participant requires an Emergency Service, First Priority Life will provide coverage at the Contracting Provider level to a Non-Contracting Provider and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been incurred if the Participant had been able to choose a Contracting Provider. For Inpatient emergency admissions to a Non-Contracting Provider, the Insured is responsible for notifying First Priority Life or its designated agent within forty-eight (48) hours of the Emergency Service or as soon as reasonably possible. Once a Participant is stabilized, to continue coverage at the higher reimbursement level, First Priority Life reserves the right to transfer the Participant's care from a Non-Contracting Provider to a Contracting Provider. Transfer expenses incurred by the Participant will be covered by First Priority Life.

C. MEDICALLY NECESSARY SERVICES

Medical Necessity for Covered Services will be determined prior to the service being rendered when Pre- Certification is required. When Pre-Certification is not required, First Priority Life may initially determine that a service was not Medically Necessary after service has been rendered. The Plan and First Priority Life only covers services, which are determined to be Medically Necessary. The Participant should be aware that services may be denied for lack of Medical Necessity after the service has been rendered. Therefore, if a Participant has a concern about a service requiring Pre-Certification, he/she should contact the Pre- Certification Department of First Priority Life prior to the service being rendered.

Based upon the evidence as required, First Priority Life shall determine the Medical Necessity for Covered Services. However, the Participants shall have the right to appeal such determinations as set forth herein.

D. EXPERIMENTAL/INVESTIGATIVE TREATMENT

The Plan does not cover services, which initially determines to be Experimental or Investigative in accordance with First Priority Life procedures. However, First Priority Life recognizes that situations occur when a Participant elects to pursue Experimental or Investigative treatment. If the Participant receives a service which First Priority Life considers to be Experimental or Investigative, the Participant is solely responsible for payment of these services. The Participant or the Provider may contact the Pre-Certification Department of First Priority Life to determine whether First Priority Life considers a service to be Experimental or Investigative.

E. TO REQUEST PRE-CERTIFICATION

For other than mental health care and Home Infusion Therapy Services, Pre-Certification can be obtained by contacting the Pre-Certification Department of First Priority Life at 1-800-638-0505 or at the following address:

Pre-Certification Department First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711

The telephone number for Pre-Certification for mental health care Covered Services is 1-800-577-3742.

Pre-Certification for Home Infusion Therapy can be obtained by contacting the Pharmacy Management Department of First Priority Life at 1-800-722-4062 or at the following address:

Pharmacy Management Department First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711-0302

F. PRE-CERTIFICATION OF SERVICES

1. Services

Pre-Certification is required to determine Medical Necessity for services and in order to allow Participant to maximize benefits in the Agreement.

With the exception of an Emergency Service or a maternity admission, Pre-Certification is required for transplant surgery and prior to Inpatient admissions in a Skilled Nursing Facility, Rehabilitation Hospital or Psychiatric Hospital regardless of whether the facility is a contracting or non-contracting facility. Pre- Certification is required prior to Inpatient admissions for certain diagnoses and Surgeries when performed as an Inpatient in a contracting facility. Pre-Certification is required for all Inpatient admissions in a non- contracting facility.

Certain procedures/surgeries performed in an acute-care Hospital's short procedure unit or free-standing surgical facility and *certain* diagnostic tests/scans require Pre-Certification, regardless of whether the Provider is a Contracting or Non-Contracting Provider.

Pre-Certification for Inpatient or Outpatient Covered Services is waived in the case of an Emergency Service or maternity admission. However, the Provider or the Participant must submit notification to First Priority Life of the Inpatient emergency admission within forty-eight (48) hours or as soon as reasonably possible.

Except for the home health care visit following a Mastectomy or the postpartum visit, Pre- Certification is required for home health care and for select Home Infusion Therapy services described in the Description of Covered Services Section regardless of whether the facility is a Contracting or Non-Contracting Provider. Certification refers only to the Medical Necessity of the services. Once the certified admission or treatment takes place, payment of

Covered Services is subject to the Participant's eligibility on the date of service.

2. Providers

The Participant is responsible to confirm with a BlueCare Service Representative that their Provider obtained Pre-Certification prior to the service being rendered.

Contracting Providers: Contracting Providers are responsible for obtaining Pre-Certification on behalf of a Participant. Contracting Providers must accept First Priority Life's determination of Medical Necessity. Contracting Providers may not bill the Participant for services, which First Priority Life determines are not Medically Necessary, unless, of course, the Insured or Provider received prior notice that the service or admission would not be covered but nonetheless elected to undergo the treatment or be admitted.

A Participant will not be responsible for payment to a Contracting Provider when the Pre-Certification was requested and First Priority Life denied the service or admission because it was not Medically Necessary, yet the Provider admitted the Participant or provided the treatment.

Non-Contracting Providers: The Participant is responsible to confirm with a BlueCare Service Representative that their Non-Preferred Provider obtained Pre-Certification prior to the service being rendered. Non-Contracting Providers are not obligated to accept First Priority Life's determination, and therefore, may bill the Participant for services determined not to be Medically Necessary. The Participant is solely responsible for payment for such services. The Participant can avoid this responsibility by choosing a Contracting Provider.

3. Penalty

Except for Inpatient emergency or maternity admissions, should the Participant fail to obtain Pre- Certification from a Non-Contracting Provider, as required; the Participant will be liable for payment of a penalty up to the first **$500** of charges for the Covered Services or as indicated on ***the Outline of Coverage***, even though the services were Medically Necessary.

In the event, however, that the Participant requires an Emergency Service, First Priority Life will provide coverage at the Contracting Provider level and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been incurred if the Participant had been able to choose a Contracting Provider.

First Priority Life only covers services, which it determines to be Medically Necessary. Should the Participant fail to obtain Pre-Certification for services rendered by a Non-Contracting Provider, as required, and it is determined that the service was not Medically Necessary, the Participant will be liable for the full cost of any services rendered.

G. CONCURRENT REVIEW

A review by a utilization review entity of all reasonably necessary supporting information, which occurs during an Participant's Hospital stay or course of treatment and results in a decision to approve or deny payments for health care services. This involves a review of all clinical information and current treatment plans. This ensures that treatment is Medically Necessary and/or being provided in the most appropriate setting. Concurrent review is performed on select Inpatient and ancillary services.

H. CASE MANAGEMENT

Notwithstanding anything in the Benefit Schedule to the contrary, First Priority Life may elect to provide Covered Services pursuant to an approved Alternative Treatment Plan for services that would otherwise not be covered. All decisions regarding the implementation of alternative care or alternative treatment to be provided to a Participant shall remain the responsibility of the treating Physician and the Participant. The Participant has the right, at any time, to have the Alternative Treatment Plan discontinued.

First Priority Life shall provide such alternative Covered Services only when and for so long as it determines that the services are Medically Necessary, cost effective relative to Covered Services that would otherwise be covered and subject to a documented Alternative Treatment Plan specifying the alternative Covered Services and their cost efficacy. The total Covered Services paid for such services will not exceed the total Covered Services to which the Participant would otherwise be entitled under the Agreement in the absence of alternative Covered Services.

If First Priority Life elects to provide alternative Covered Services for a Participant in one instance, it shall not be obligated to provide the same or similar Covered Services for any Participant in any other instance, nor shall it be construed, as a waiver of its right to administer the Agreement thereafter in strict accordance with its expressed terms.

SCHEDULE OF COVERED SERVICES FOR COVERED MEDICAL EXPENSES

Subject to the exclusions, conditions and limitations of ***the Outline of Coverage***, a Participant is entitled to Covered Services described in the Benefit Schedule and is responsible for the Deductible, Copayment and Coinsurance, if any, as specified in ***the Outline of Coverage***. ***The Outline of Coverage specifies the Benefit Period selected by the Plan.***

A charge for a Covered Service shall be considered incurred on the date the service or supply was provided to a Participant. The payment amount is based on the Allowable Charge at the time the service is rendered.

Subject to the provisions of the Benefit Schedule, a Participant is responsible for payment of any cost-sharing amounts due to the Provider.

COPAYMENT – The amount, if any, a Participant must pay directly to Providers in connection with Inpatient services provided in a Hospital, Skilled Nursing Facility, or Rehabilitation Hospital, as well as Inpatient services for maternity care, mental health care and Detoxification, as set forth in the Benefit Schedule and in ***the Outline of Coverage***. The amount, if any, is per person per day for the number of days set forth in ***the Outline of Coverage***. Copayments for procedures for the surgical treatment of Morbid Obesity and for a panniculectomy are set forth in the Description of Covered Services Section.

COINSURANCE – Payment will be made in each Benefit Period on behalf of a Participant for the percentage of the Allowable Charge for Covered Medical Expenses as specified below and as included in ***the Outline of Coverage***:

- For Covered Services rendered by *Contracting Providers*, First Priority Life will pay **100%** of the Allowable Charge in each Benefit Period on behalf of the Participant, (except for the removal of bony impacted wisdom teeth[2] which is paid at **50%** of the Allowable Charge) by which the Allowable Charge exceeds any Deductible amounts. ***The Outline of Coverage specifies the Deductible amounts, if any, that apply to Professional Covered Services.***

- For Covered Services rendered by *Non-Contracting Providers*, First Priority Life will pay **70%** of the Allowable Charge in each Benefit Period on behalf of the Participant, by which the Allowable Charge exceeds any Deductible amounts. ***The Outline of Coverage specifies the Deductible amounts, if any, that applies to Professional Covered Services.***

[2] Coverage for the removal of bony impacted wisdom teeth is limited to services of Contracting Providers as described in the Description of Covered Services Section of the Agreement.

The Participant is responsible for **30%** of the Allowable Charge. The Participant is also responsible for the difference between First Priority Life's payment and the Provider's billed charge. This liability of the Participant applies to all Covered Services, except the postpartum home health care visit. Covered Services provided by a Non-Contracting Provider for Outpatient emergency accident services and Outpatient medical Emergency Services are payable at a rate at which the Participant will not incur a greater Out-Of-Pocket expense than would had been incurred had the Participant been able to choose a Contracting Provider.

- For major medical Covered Services, payment will be made in each Benefit Period on behalf of an Participant for the percentage of the amount, as specified in the Declaration and the Outline of Coverage, (except for Ostomy Supplies[3] which are paid at 50%of the Allowable Charge) by which the Allowable Charges exceed the major medical Deductible. ***The Outline of Coverage*** specifies the Deductible amounts that apply to major medical Covered Services. Coinsurance does not apply to Outpatient Mental Health care services and to Nutritional Therapy.

- Listed in the order described in Section DB – Description of Covered Services, the eligible Covered Services under major medical are as follows:

  - Physician office visits;
  - Outpatient Physical, Speech, Occupational, Cardiac Rehabilitation, Pulmonary and Respiratory Therapies;
  - Nutritional Therapy;
  - Outpatient mental health care services;
  - oxygen and related equipment/supplies (used in home setting);
  - diabetic equipment and supplies;
  - initial prescription of cataract glasses or contact lenses after cataract Surgery, - Chiropractic Covered Services;

- Durable Medical Equipment/Prostheses/Orthoses; and
- Ostomy Supplies.

COINSURANCE MAXIMUM – Coinsurance Maximum applies to major medical Covered Services. When a Participant incurs the amount of Coinsurance expense as specified in ***the Outline of Coverage*** in a Benefit Period for major medical Covered Services, the Coinsurance percentage will be reduced to **0%** for the balance of that Benefit Period except for Ostomy Supplies which are paid at **50%** of the Allowable or as indicated on ***the Outline of Coverage***.

The **Coinsurance Maximum** does not include Deductibles, amounts in excess of the Allowable Charge, and charges for non-Covered Services, and charges after the Plan Covered Services limits for Services have been exhausted.

The eligible Coinsurance amounts, which are incurred by three (3) separate family members covered under the Plan, may be contributed to the family Coinsurance Maximum. When three (3) separate Participants covered under the same family coverage have incurred the Coinsurance Maximum for a family for a Benefit Period, which is three (3) times the amount for an individual, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period except for Ostomy Supplies which are paid at **50%** of the Allowable Charge or as indicated on ***the Outline of Coverage.*** No one family member's Coinsurance may exceed the individual limits. ***The Outline of Coverage specifies the Coinsurance Maximum that applies to major medical Covered Services.***

DEDUCTIBLE – When a Deductible applies, it applies per Participant per Benefit Period to all major medical Covered Services and a separate Deductible applies to Professional Provider Covered Services with the exception of the following: Outpatient Emergency Service, emergency ambulance, childhood immunizations, adult

[3] Coverage for Ostomy Supplies is limited to services of Contracting Providers as described in the Description of Covered Services Section of the Agreement.

immunizations, removal of bony impacted wisdom teeth, routine gynecological examinations and Pap Smears, postpartum home health care visit, Metabolic Formulas, mammograms, routine colorectal cancer screenings, routine prostate cancer screenings, preventive drugs, preventive physician office visits, Nutritional Therapy, Outpatient Mental Health care services, Inpatient Mental Health care services, Inpatient Non-Hospital Residential Care, and Inpatient Detoxification. ***The Outline of Coverage*** specifies the Deductible amounts that apply to major medical Covered Services and to Covered Services of Professional Providers.

For major medical Covered Services, the eligible Deductible amounts, which are incurred by the three (3) separate family members covered under the Plan, may be contributed to the family Deductible, which is three (3) times the amount for an individual in any one Benefit Period. No one family member's Deductible expense may exceed the individual Deductible. Deductible and Coinsurance amounts for family members that did not satisfy the individual limits will not be refunded in the event the family Deductible or family Coinsurance Maximum is met by the specified number of separate family members. ***The Outline of Coverage specifies the Deductible that applies to major medical Covered Services.***

MEDICAL LIFETIME BENEFIT MAXIMUM is unlimited per lifetime, per Participant.

CROSS PRODUCT ACCUMULATION – If a Participant changes products offered by First Priority Life, its affiliated companies (Blue Cross of Northeastern Pennsylvania, Highmark Blue Shield, or First Priority Health) while with the same Plan during a Benefit Period, or if a Participant changes Deductibles during a Benefit Period while with the same Plan, eligible expenses, which were applied to the original Deductible and Coinsurance Maximum, will be eligible for credit towards the new Deductible and Coinsurance Maximum amounts during the remainder of that same Benefit Period.

The "Credit" section of the Outline of Coverage specifies the option selected by the Plan which is applicable to expenses for major medical and Professional Provider Covered Services.

PRO-RATION OF DEDUCTIBLE – If the Plan's Effective Date falls within the last nine (9) months of a Calendar Year, the Deductible under the Plan will be prorated for the number of quarters remaining in that Calendar Year. For example, a Plan with a Calendar Year Deductible would be prorated as follows:

Policy Effective Date	Initial Benefit Period
April-June	75% of Deductible
July-September	50% of Deductible
October-December	25% of Deductible

The initial Benefit Period is the period of time from the initial Effective Date of the group through the end of the Calendar Year in which the Plan offered the option.

PRIOR CARRIER CREDIT – If the Plan changes carriers during a Plan's Benefit Period, Covered Expenses which were incurred and applied to the Deductible and Coinsurance Maximum by the prior carrier during such Benefit Period shall be credited by First Priority Life toward the initial Benefit Period under this new Plan for those Eligible Employees and Dependents who are enrolled with the Plan during the initial Benefit Period.

In order for First Priority Life to accept and apply Deductible and/or Coinsurance Maximum amounts, the Plan, the Participant or their prior carrier must supply the required data. If the required data is insufficient and/or not received prior to the Effective Date of the Plan, First Priority Life reserves the right not to apply this provision.
The initial Benefit Period is the initial Effective Date of the Plan.

DESCRIPTION OF COVERED SERVICES

Subject to the exclusions, conditions and limitations of ***the Outline of Coverage***, a Participant is entitled to Covered Services as described in the Benefit Schedule, in accordance with the Deductible, Copayment and Coinsurance, if any, and in the amounts as specified in ***the Outline of Coverage***. ***The Outline of Coverage also specifies the Benefit Period selected by the Plan.***

The Participant is always responsible for Copayments, Deductibles and Coinsurance in the amounts shown for Covered Services as included herein, in the Outline of Coverage that accompanies the Benefit Schedule.

Pre-Certification requirements must be followed as discussed in Care Coordination section. Inpatient emergency admissions must be reviewed within forty-eight (48) hours of the admission, or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what has been pre-certified by First Priority Life.

A. HOSPITAL SERVICES

1. Room and Board

Covered Services are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

a. a Semi-Private Room, as designated by the Hospital; or a private room, when designated by First Priority Life as semi-private for the purposes of the Agreement, in Hospitals having primarily private rooms;

b. a private room. The private room allowance is the Semi-Private Room charge;

c. a special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;

d. a bed in a general ward; and

e. nursery facilities.

Covered Services are payable for a length of stay following a Mastectomy that a treating Physician determines is necessary to meet generally accepted criteria for safe discharge.

Covered Services are provided for an unlimited number of days per Benefit Period.

In computing the number of days of Covered Services, the day of admission, but not the date of discharge, shall be counted. If the Participant is admitted and discharged on the same day, it shall be counted as one day.

Covered Services are payable for hospital services for an Inpatient admission resulting from an accident or Emergency Medical Condition that a treating Physician determines is Medically Necessary.

Days available under the Agreement shall be allowed only during uninterrupted stays in a Hospital. Covered Services shall not be provided: (1) for any day during which a Participant interrupts his/her stay; or (2) after the discharge hour that the Participant's attending Physician has recommended that further Inpatient care is not required.

2. Ancillary Services

Covered Services are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items), including, but not limited to the following:

a. meals, including special meals or dietary services as required by the patient's condition;

b. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;

c. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by First Priority

d. oxygen and oxygen therapy;

e. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Blood and Blood Plasma of this Section;

f. anesthesia and the supplies and use of anesthetic equipment;

g. Diagnostic Services;

h. Therapy Services;

i. Inpatient rehabilitation therapy limited to forty-five (45) days per Benefit Period or as indicated on ***the Outline of Coverage***;

j. all FDA-approved drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;

k. use of special care units, including, but not limited to, intensive or coronary care; and

l. pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a diagnosis. Covered Services for pre-admission testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancels or postpones the admission, Covered Services will be provided.

Covered Services are payable for ancillary services provided for and billed for by the Hospital for an Inpatient admission resulting from an accident or Emergency Medical Condition.

B. OBSERVATION STATUS

Services furnished on a Hospital’s premises include use of a bed and periodic monitoring by Hospital’s nursing or other staff, which are reasonable and necessary to evaluate an Outpatient’s condition or determine the need for a possible admission to the Hospital as an Inpatient.

C. EMERGENCY CARE COVERED SERVICES

Emergency care Covered Services include treatment and services provided in the Outpatient department of a Hospital for an Emergency Medical Condition.

- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of bodily injury resulting from an accident shall be covered.

- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of a medical condition with acute symptoms, which would result in requiring immediate Medical Care, shall be covered.

If accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical Covered Services.

Visits performed in the Outpatient department of a Hospital that are follow-up to emergency accident care and emergency Medical Care are classified and payable as Outpatient Covered Services.

D. SURGERY

1. Surgical Covered Services

Surgery Covered Services will be provided for services rendered by a Professional Provider and/or Facility Provider in a Physician's office or in a short procedure unit, Hospital, Outpatient department, or Freestanding Outpatient Facility for the treatment of disease or injury. Separate payment will not be made for Inpatient pre-operative care or all post-operative care normally provided by the surgeon as part of the surgical procedure.

For questions concerning Pre-Certification, the Participant should contact First Priority Life by calling a BlueCare Service Representative prior to the service being rendered. Ambulatory Surgery (i.e., Surgery performed in an acute-care Hospital's short procedure unit or a free-standing surgical facility) requires Pre- Certification by First Priority Life for *certain* procedures, regardless of Provider. Outpatient Surgery (i.e., Surgery performed in a Physician's office or in an acute-care Hospital's Outpatient department) also requires Pre-Certification of *certain* procedures by First Priority Life regardless of Provider.

- Upon Pre-Certification, Surgery Covered Services are covered for the surgical treatment of Morbid Obesity, provided the Insured is at least eighteen (18) years of age. This Covered Service is limited to one (1) procedure per lifetime or as indicated on ***the Outline of Coverage***.

- When a panniculectomy is Medically Necessary, upon Pre-Certification it is limited to one (1) procedure per lifetime for those eighteen (18) years of age or older. When this Surgery is performed by a Contracting Provider, the Participant may be responsible for a Copayment of **$1 ,000** or as indicated on ***the Outline of Coverage***.

- Reconstructive Surgery will only be covered when required to restore function following accidental injury, infection, or disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of eighteen (18); or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy.

- Covered surgical procedures shall also include routine neonatal circumcision. Voluntary surgical procedures for sterilization regardless of Medical Necessity and Surgery performed for the reversal of sterilization are not covered.

- Covered Services are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:

  a) Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;

  b) Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and

  c) Physical complications of all stages of Mastectomy, including lymphedemas.

Coverage is also provided for one (1) home health care visit, as determined by the Participant's Physician, received within forty-eight (48) hours after discharge.

- The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus is covered.

2. Assistant Surgeon

Covered Services will be payable for services by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery for a Participant. The condition of the Participant or the type of Surgery must require the active assistance of an assistant surgeon as determined by First Priority Life. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

3. Removal of Bony Impacted Wisdom Teeth

The removal of partially or totally bony impacted wisdom teeth, when performed by a contracting Professional Provider in other than a Hospital or Ambulatory Surgical Facility, will be covered.

The Surgery cannot be safely or adequately performed in other than a Hospital or Ambulatory Surgical Facility and if authorized by a Medical Director of First Priority Life for.

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Participant's health.

General anesthesia charges will be covered for removal of bony impacted wisdom teeth in a Hospital or Ambulatory Surgical Facility if authorized by a Medical Director of First Priority Life for:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Participant's health.

Local anesthesia and conscious sedation are covered regardless of setting.

4. Physician, Hospital or Ambulatory Surgical Facility Charges for Dental Procedures or Dental Surgery

Dental procedures are not covered as set forth in Section EX, Exclusions, Paragraph 16. Covered Service will be payable for Physician, Hospital or Ambulatory Surgical Facility charges in connection with dental procedures or dental Surgery performed in a Hospital or Ambulatory Surgical Facility when approved by a Medical Director of First Priority Life under the following circumstances:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Insured Persons with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Insured Person's health, or
- When one of the following is present:

a) It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
b) There is non-dental diseases eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Participant's teeth.
c) There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant

5. Oral Surgery

Oral Surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Service only for treatment of diseases and injuries of the jaw, head and neck. Surgery for the treatment of diseases of the teeth or gums is not covered as set forth in Section EX – Exclusions, Paragraph 16.

Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures are not covered unless such procedures were for the treatment of accidental bodily injury or as described in Subsection D, Paragraph 4 above.

6. Dental Services related to Accidental Injury

Dental services rendered by a Professional Provider and/or a Facility Provider, as a result of accidental injury to the jaws, natural teeth, mouth or face, are covered when performed for immediate post injury stabilization. Injury as a result of chewing or biting shall not be considered an accidental injury.

Dental implants are excluded from Covered Services as set forth in Section EX – Exclusions, Paragraph 16.

7. Dental Services Related to Early Childhood Caries (ECC)

Dental services directly associated with early childhood caries (ECC), prior to age (4), are limited to one (1) treatment per

Participant per lifetime.

8. Eyeglasses or Contact Lenses following Surgery

Coverage will be provided for eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e., cataract Surgery) or injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:

i. contact lenses used for treatment of infantile glaucoma;
ii. corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
iii. scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
iv. corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

Coverage will be provided for the initial prescription of cataract glasses or contact lenses, with or without an implant, after cataract Surgery. Post-cataract prescription glasses or contact lenses are limited to the initial pair of glasses or contact lenses per lifetime per Participant

E. ANESTHESIA

Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility when in connection with the performance of Covered Services and when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Profession Provider is covered.

Coverage for general anesthesia in connection with the extraction of partially or totally bony impacted wisdom teeth, is described in Subsection D, Paragraph 3 above.

Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with the performance of non-covered dental procedures or non-covered oral Surgery is covered when approved by a Medical Director of First Priority Life under the following circumstances:

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the Participant's health, or
- When one of the following is present:

a) It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
b) There is non-dental diseases eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Insured Participant's teeth.
c) There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant.

Local anesthesia and conscious sedation are covered regardless of setting.

F. SECOND SURGICAL OPINION

Second opinion consultations for Surgery to determine the Medical Necessity of an elective surgical procedure are covered. Elective Surgery is Surgery that is not for an emergency or life-threatening condition.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

G. TRANSPLANT SURGERY

If a human organ or tissue transplant is provided from a human donor to a human transplant recipient:

1. When both the recipient and the donor are Participants, each is entitled to the Covered Services of the Plan.

2. When only the recipient is a Participant, both the donor and the recipient are entitled to the Covered Services of the Plan. The donor Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to: other insurance coverage, or coverage by First

Priority Life or any government program. Covered Services provided to the donor will be charged against the recipient's coverage under the Plan to the extent Covered Services remain and are available under the Plan after the Covered Services of the recipient have been paid.

3. When only the donor is a Participant, the donor is entitled to the Covered Services of the Plan. The Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by First Priority Life or any government program available to the recipient. No Covered Services will be provided to the non-Participant transplant recipient.

4. If any organ or tissue is sold rather than donated to the Participant recipient, no Covered Services will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Participant recipient's Plan limit.

5. If the Participant's coverage includes Prescription Drug coverage, the immunosuppressant drugs in connection with covered transplants will be covered under the Prescription Drug Coverage Section of the Plan and the cost of these drugs is detailed in ***the Outline of Coverage***.

Pre-Certification is required as set forth in Section CC – Care Coordination.

H. CONCURRENT CARE

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Participant, standby services, routine pre-operative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

I. CONSULTATIONS

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations, which are required by Facility Provider's rules and regulations.

Covered Services are limited to one (1) consultation per consultant during any Inpatient confinement.

J. PHYSICIAN OFFICE VISITS

Covered Services are provided for Medical Care, visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient. Covered Services are provided for the examination, diagnosis, and treatment of an illness or injury. With the exception of visits and consultations for Chiropractic Manipulative Treatment, there is an unlimited visit Maximum per Benefit Period. For Chiropractic
Manipulative Treatment, the Participant is subject to the combined Maximum included in the Description of Covered Services Section.

K. THERAPEUTIC DRUGS THAT ARE NOT SELF-ADMINISTRABLE

Covered Services are provided for FDA-approved therapeutic drugs, including cancer Chemotherapy and cancer hormone treatment that are not self-administrable and required in the treatment of an illness or injury in all medically appropriate treatment settings covered by the Plan.

L. DIAGNOSTIC SERVICES-OUTPATIENT

Certain diagnostic tests/scans require Pre-Certification, regardless of whether the Provider is a Preferred or Non-Preferred Provider. Covered Services are provided for the following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, independent clinical laboratory, and/or a Facility Provider:

1. Diagnostic radiology, consisting of x-ray, ultrasound, and nuclear medicine.

Diagnostic mammograms, which are recommended by a Physician, are covered for all Participants. Diagnostic mammograms performed by a Contracting Professional Provider are exempt from all Deductibles, Coinsurance and Copayments.

2. Diagnostic laboratory and pathology tests. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life.

3. Allergy testing consisting of percutaneous, intracutaneous and patch tests. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan, and nuclear cardiology studies approved by First Priority Life.

M. THERAPY SERVICES-OUTPATIENT

Covered Services shall be provided, subject to the Maximums specified, for the following services prescribed by a Physician and performed by a Professional Provider and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Participant.

1. Cardiac Rehabilitation Therapy is limited to a Maximum of thirty-six (36) visits per Benefit Period or as indicated on ***the Outline of Coverage***.

2. Dialysis Treatment.

3. Pulmonary Rehabilitation Therapy is limited to a Maximum of eighteen (18) visits per Benefit Period or as indicated on ***the Outline of Coverage***..

4. Radiation Therapy, including the cost of radioactive materials.

5. Respiratory Therapy is limited to a Maximum of eighteen (18) visits per Benefit Period or as indicated on ***the Outline of Coverage***..

6. Short term therapy is Occupational, Physical, or Speech Therapy which:

   - is prescribed by a Physician,
   - is Medically Necessary to regain lost function after an accidental injury, Surgery, or an acute illness, and
   - will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

Outpatient Occupational, Physical, and Speech Therapy Covered Services are limited to the following or as indicated on ***the Outline of Coverage***:

(a) Occupational Therapy is limited to a Maximum of twelve (12) visits per Benefit Period.
(b) Physical Therapy is limited to a Maximum of twenty (20) visits per Benefit Period.
(c) Speech Therapy is limited to a Maximum of twelve (12) visits per Benefit Period.

7. When Physical, Occupational, and/or Speech Therapy Services are provided to a Participant in conjunction with a Treatment Plan for Autism Spectrum Disorder, the Benefit Period Maximum for these Therapy Services will not be reduced unless the Therapy Service provided is for other than Autism Spectrum Disorder. Once the Benefit Period Maximum has been reached, no additional Physical, Occupational, and/or Speech Therapy benefits are available under the agreement for the remainder of the Benefit Period for treatment of Autism Spectrum Disorder.

Outpatient Cardiac Rehabilitation, Pulmonary Rehabilitation, Respiratory, Physical, Speech and Occupational Therapies are major medical Covered Services.

N. MATERNITY SERVICES

Services rendered in the care and management of a pregnancy for a Participant are Covered Services under the Plan. Covered Services are payable for:

1. Normal Pregnancy

Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy, but not considered a complication of pregnancy.

2. Complications of Pregnancy

Physical effects directly caused by pregnancy, but which were not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

3. Minimum Length of Stay

Coverage will be provided for a minimum of forty-eight (48) hours of Inpatient care following normal vaginal delivery and ninety-six (96) hours of care following cesarean delivery. A shorter length of stay may be justified when the treating or attending Physician determines in consultation with the mother that she and the newborn meet medical criteria for safe discharge in accordance with guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Those guidelines determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant post-discharge; and the availability of the post-discharge follow-up care to verify the condition of the infant and mother within forty-eight (48) hours after discharge.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits 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. The postpartum home health visit is exempt from any Deductibles, Coinsurance or visit limits.

4. Interruptions of Pregnancy

a. Miscarriage.

b. Services, which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest.

5. Nursery Care

Ordinary nursery care of the newborn infant.

6. Routine Newborn Care

The newborn child of any covered Participant, spouse, or Dependent shall be entitled to Covered Services provided by the Plan from the date of birth up to a Maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care, which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, pre-maturity and routine nursery care. Coverage for a newborn may be continued beyond thirty-one (31) days by enrolling the newborn child as a Dependent under the Plan, provided that all premium payments required are paid for such child.

If the newborn does not otherwise qualify for coverage as a Dependent, the child will be entitled to Hospital service during the thirty-one (31) days after birth. In order to continue coverage for the newborn beyond this time, Application for membership must be made within thirty-one (31) days of the date of birth.

Routine neonatal circumcision is covered.

O. ARTIFICIAL INSEMINATION

Artificial insemination is covered for three (3) attempts per lifetime or as indicated in ***the Outline of Coverage***. Associated diagnostic, medical, and surgical services are considered part of the artificial insemination procedure.

P. MENTAL HEALTH CARE SERVICES

Covered Services for the treatment of Mental or Nervous Disorders and for the treatment of Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as mental health care are subject to the mental health care limitations in ***the Outline of Coverage***. When a Provider renders Medical Care, other than mental health care, for a Participant with Serious Mental Illness or with a Mental or Nervous Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be subject to the mental health care limitations in ***the Outline of Coverage***.

Except in an emergency, Inpatient and Partial Hospitalization Covered Services are provided when Medically Necessary and when the Community Behavioral Healthcare Network of Pennsylvania (CBHNP) is notified by the Provider or the Participant before the Covered Services are rendered. Pre-Certification procedures apply as set forth in Section CC – Care Coordination.

1. Inpatient Services

Inpatient Services will be provided for admissions for Serious Mental Illness and Mental or Nervous Disorders in an

Inpatient Mental Health Hospital. Pre-Certification requirements must be followed as discussed in Section CC – Care Coordination. A concurrent review is required for any continued length of stay beyond what has been pre-certified by CBHNP.

2. Outpatient Services

Outpatient services will be provided during a Benefit Period for Mental or Nervous Disorders and for Serious Mental Illness.

Outpatient mental health care services include Outpatient professional visits and Outpatient Partial Hospitalization days.

Q. TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE AND DEPENDENCY

Covered Services are available to an Participant who is certified by a licensed Physician or licensed Psychologist as a person who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient and Outpatient Substance Abuse treatment. The certification must be provided to Community Behavioral Healthcare Network of Pennsylvania (CBHNP) before claims for the treatment rendered will be processed for payment.

Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Drug and Alcohol treatment by non-Physicians/Psychologists must be pre-certified with CBHNP before services are rendered and must meet Medical Necessity criteria.

1. Inpatient Detoxification

Covered Services are provided for Inpatient Detoxification when provided in either a Hospital or in an

Inpatient Non-Hospital Residential Facility. The following services will be covered when administered by an employee of the facility:

a. lodging and dietary services;
b. rehabilitation therapy and counseling;
c. diagnostic x-ray;
d. psychiatric, psychological and medical laboratory testing; and
e. drugs, medicines, equipment use and supplies.

2. Inpatient Non-Hospital Residential Care

Covered Services are provided for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility.

The following services will be covered when administered by an employee of the facility:

a. lodging and dietary services;
b. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
c. rehabilitation therapy and counseling;
d. family counseling and intervention;
e. psychiatric, psychological and medical laboratory testing; and
f. drugs, medicines, equipment use and supplies.

3. Outpatient Facility Services for Treatment of Alcohol or Drug Abuse

Covered Services are provided for Outpatient Alcohol and/or Drug Abuse services when provided in a Substance Abuse Treatment Facility. The following services will be covered when administered by an employee of the facility:

a. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
b. rehabilitation therapy and counseling;
c. family counseling and intervention;
d. psychiatric, psychological and medical laboratory testing; and
e. drugs, medicine, equipment use and supplies.

R. OXYGEN AND RELATED EQUIPMENT/SUPPLIES

Oxygen and related equipment and supplies for use in the patient's home are covered. Oxygen and related equipment/supplies are not subject to any Maximum.

S. SKILLED NURSING FACILITY

Covered Services are provided for care in a Skilled Nursing Facility, when determined to be Medically Necessary by First Priority Life, up to sixty (60) days per Benefit Period or as indicated on ***the Outline of Coverage***. The Participant must require treatment by skilled nursing personnel, which can be provided only on an Inpatient basis in a Skilled Nursing Facility. Pre-Certification procedures apply as set forth in Section CC – Care Coordination.

The Participant's attending Physician must provide First Priority Life with clinical information that skilled nursing care in a Skilled Nursing Facility is Medically Necessary pursuant to Section CC – Care Coordination.

No Covered Services are payable:

1. after the Participant has reached the Maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care;

2. when confinement in a Skilled Nursing Facility is intended solely to assist the Participant with the activities of daily living or to provide an institutional environment for the convenience of a Participant; or

3. for the treatment of alcoholism, drug addiction, or mental illness

T. HOME HEALTH CARE

As indicated on ***the Outline of Coverage***, subject to the following provision, Covered Services will be provided for unlimited home health care visits per Benefit Period. With the exception of services provided in conjunction with Home Infusion Therapy and the post Mastectomy visit, the Participant must be Homebound in order to receive home health care Covered Services.

The Participant must be Homebound in order to receive home health care Covered Services, except when services are provided in conjunction with:

- Home Infusion Therapy, including the care of venous lines;
- The post Mastectomy visit; and
- The post-partum visit; or
- When services are not routinely provided in a Physician's office or the Outpatient setting and are Medically Necessary and have approval of First Priority Life's Medical Director.

Covered Services will be provided only for Covered Services if (a) the services are prescribed by the Participant's attending Physician, (b) the Participant received Pre-Certification approval from First Priority Life as set forth in Section CC - Care Coordination, and (c) the Participant's Physician has furnished, in consultation with the Home Health Care Agency's professional personnel prior to the first visit, a plan of treatment stating that the services are Medically Necessary. Continuing eligibility requires that the attending Physician provide such a plan of treatment at intervals of no less than every thirty (30) days.

Covered Services will be provided for the following Covered Services when performed by a licensed Home Health Care Agency:

1. professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;

2. home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;

3. Physical Therapy treatments performed by a licensed Physical Therapist;

4. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;

5. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;

6. medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;

7. Nutritional Therapy provided by a Licensed Dietitian[4];

8. diagnostic and therapeutic radiology services;

[4] Nutritional Therapy provided to a Homebound Participant will not reduce the Covered Service provided under the Description of Covered Services Section of the Agreement.

9. laboratory services;

10. medical diagnostic tests and studies;

11. oxygen and Respiratory Therapy;

12. medical and surgical supplies, including bandages, ostomy supplies, dressing and casts[5]; and

13. the rental of Durable Medical Equipment but only on a short term basis and if not owned by the Home Health Care Agency.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a Mastectomy, Covered Services will be provided for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

At the discretion of the mother, a visit may occur at home or at the facility of the Provider. A visit occurs when the Participant receives such treatment from one of the qualified professionals as listed above under the Covered Services of this Covered Service section. Postpartum home health care visits are exempt from any Coinsurance or Deductible amounts.

No home health care Covered Services will be provided for:

1. food or home delivered meals;

2. professional Medical Services billed by a Physician;

3. Custodial Care;

4. services of a housekeeper;

5. Private Duty Nursing;

6. ambulance service;

7. drugs, including Prescription Drugs; and

8. services provided by Immediate Family or members of the Participant's household.

U. HOME INFUSION THERAPY

Covered Services will be provided for the following services provided to a Participant by a Home Infusion Therapy Agency:

1. total parenteral nutrition *;
2. enteral nutrition *;
3. intravenous therapy;
4. cancer Chemotherapy and cancer hormone treatment;

[5] Ostomy Supplies provided to a Homebound Participant as part of Home Health Care will not reduce the Covered Services provided under Ostomy Supplies the Description of Covered Services Section of the Agreement.

5. anti-infective therapy (* Lyme Disease);
6. pain management (continuous and epidural analgesics); and
7. immune globulin therapy *.

The Home Infusion Therapy Agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic benefits and to assure proper functioning of the system, including, but not limited to: catheters, concentrated nutrients, dressings, enteral nutrition preparation, extension tubing, filters, heparin sodium (parenteral only), infusion bottles, IV pole, liquid diet (for catheter administration), needles, pumps, tape and volumetric monitors.

All therapies are subject to prospective, concurrent and/or retrospective utilization review by health care professionals, and further may require Pre-Certification to determine if a therapy is Medically Necessary and appropriate. Before delivering the therapy, a preferred Home Infusion Therapy Agency will advise the Participant if Pre-Certification is required.

* Therapies that generally require Pre-Certification are noted with an asterisk above. Any therapy or drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be pre- certified.

Pre-Certification procedures apply as set forth in Section CC – Care Coordination. Home Infusion

Therapy Covered Services will not be provided for:

a. Participants who are receiving Covered Services under the Hospice Care program;
b. blood and blood products therapy; and
c. any injectable drugs covered under any other Covered Services section of the Benefit Schedule.

V. METABOLIC FORMULAS

Metabolic Formulas only for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. This Covered Service does not include coverage for normal food products used in the dietary management of rare genetic metabolic disorders. Covered Services for Metabolic Formulas are exempt from any Deductible requirements.

W. HOSPICE CARE

When the Participant's attending Physician certifies to First Priority Life that the Participant has a terminal illness with a life expectancy of six (6) months or less and when the Participant elects to receive care primarily in the home to relieve pain and to enable the Participant to remain at home rather than to receive other types of care, the Participant shall be eligible for Hospice Care Covered Services.

Covered Services for Hospice Care shall be provided for up to one-hundred eighty (180) days or as indicated on ***the Outline of Coverage***. These Covered Services are in addition to, and not in lieu of, any other Covered Services in the Benefit Schedule. If the Participant or the Participant's responsible party elects to institute curative treatment to sustain life, the Participant will not be eligible to receive further Hospice Care Covered Service until the cessation of such curative treatment.

The Hospice Care Covered Service will include, coverage for continuous care consisting of nursing care for up to twenty-four (24) hours per day necessary to maintain the patient at home or acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures. A Maximum of thirty (30) days (of the 180-day Lifetime Benefit Maximum) or as indicated on ***the Outline of Coverage*** is available for continuous and/or Inpatient care. Respite Care on a short-term Inpatient basis in a Hospital or Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient’s home. Respite Care is available with a Maximum of ten (10) days per lifetime (of the 180-day Lifetime Benefit Maximum) or as indicated on ***the Outline of Coverage***. Covered Services are payable according to the Maximums set forth in herein.

Covered Services will be provided for supportive services at each level of care to a terminally-ill Participant by a Hospice Care program in accordance with a treatment plan approved by and periodically reviewed by First Priority Life. The following services provided to a Participant by an approved Hospice responsible for the patient's overall care will be eligible for coverage:

1. professional services of a Registered Nurse or Licensed Practical Nurse;

2. pain management;

3. Chemotherapy and/or Radiation Therapy;
4. parenteral or enteral nutrition therapy;
5. prescription drugs;
6. laboratory services;
7. dietitian services;
8. medical and surgical supplies, ostomy supplies, and Durable Medical Equipment[6];
9. oxygen and its administration;
10. medical social service consultation provided by a social worker;
11. counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
12. home health aide and homemaker services; and
13. any needed therapies.

X. DIABETES EDUCATION/EQUIPMENT/SUPPLIES

Diabetes Education

Covered Services are provided for diabetes education services as described herein. Diabetes Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self- management education and education relating to diet and prescribed by a licensed Physician shall include: (1) visits Medically Necessary upon the diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

Diabetic Equipment and Supplies

Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational

[6] Ostomy Supplies provided to a Participant as part of Hospice Care will not reduce the Covered Service provided under Ostomy Supplies the Description of Covered Services Section of the Agreement.

Diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses.

Equipment and supplies must be prescribed by a licensed Provider and are subject to applicable Deductibles and Coinsurance. Equipment and supplies prescribed as a result of diabetes as set forth in this Subsection are not subject to the Maximum set forth in Ostomy Supplies the Description of Covered Services Section of the Agreement.

If the Participant's coverage includes Prescription Drug coverage, the Participant is responsible for the applicable Deductible, Coinsurance or the Copayment. The Copayment, Coinsurance, or Deductible, if any, is paid by the Participant directly to the Pharmacy for each Prescription. ***The Outline of Coverage specifies if Prescription Drug coverage applies and the Deductible, Coinsurance or Copayment amounts.***

If the Participant's coverage does not include Prescription Drug coverage, there is a **$0 Tier 0**, **$10 Tier 1**, **$25 Tier 2**, and **$45 Tier 3** or as indicated on the Outline of Coverage, Prescription Drug Copayment payable by the Participant directly to the Participating Pharmacy for each Prescription; there is a **$0 Tier 0**, **$20 Tier 1**, **$55 Tier 2**, and **$135 Tier 3** or as indicated on the Outline of Coverage, mail order Prescription Drug Copayment payable by the Participant directly to the Participating Mail Order Pharmacy Provider.

The Covered Services provided for equipment and supplies, pharmacological agents and Orthoses for the treatment of diabetes, are only available under the Plan when the Participant is not enrolled for Prescription Drug coverage through another Prescription Drug program.

Y. BLOOD AND BLOOD PLASMA

Covered Services will be provided for whole blood, blood plasma, the administration of blood and blood processing, and blood derivatives, which are not classified as drugs by the U.S. Food and Drug Administration ("FDA").

Z. AMBULANCE SERVICES

Covered Services are payable for Medically Necessary ambulance services by land, air or water, Advanced Life Support (ALS) or Basic Life Support (BLS) for local transportation. The ambulance must be transporting the Participant:

1. from home or from the scene of an accident or Medical Emergency, to the nearest Hospital;
2. between Hospitals;
3. between a Hospital and Skilled Nursing Facility;
4. from a Hospital or Skilled Nursing Facility to the Participant's home;
5. from the Participant's home or from a Facility Provider to an Outpatient treatment site; or
6. from an Outpatient treatment site to the nearest Hospital.

If there is no facility in the local area that can provide Covered Services for the Participant's condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service. If the Participant chooses to go to another facility that is farther away, payment will be based on the Allowable Charge for transportation to the closest facility that can provide the necessary services.

AA. PREVENTIVE CARE

Coverage will be provided for the preventive care services provided for in the Patient Protection and Affordable Care Act. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive Care services include, but are not limited to the following:

1. Immunizations

Coverage will be provided for those pediatric immunizations, including 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 available until the Insured Person attains age twenty-one (21). Covered Services for pediatric immunizations are exempt from Deductibles, Coinsurance, and Copayments, when provided by a Contracting Provider.

Covered Services are also provided for other immunizations, including immunizing agents, which are determined to be Medically Necessary.

2. Routine Gynecological Examinations and Pap Smears

Female Participants are covered for one (1) gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine Pap smear per Benefit Period. Covered Services are exempt from Deductibles, Copayments and Coinsurance, when provided by a Contracting Provider.

3. Screening Mammograms

Screening mammograms are covered for all Participants whether or not directed toward a definite condition of disease or injury. Covered Services are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Contracting Provider.

4. Colorectal Cancer Screening

Coverage for colorectal cancer screening is provided for covered individuals.

Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.

Coverage for non-symptomatic covered individuals shall include, but is not limited to:

i. One (1) fecal occult blood test per Benefit Period.
ii. Sigmoidoscopy, screening barium enema, colonoscopy, or a test consistent with approved medical standards and practices to detect colon cancer, at a frequency determined by the covered individuals Physician.

Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Contracting Provider.

5. Prostate Cancer Screening

Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal exam per Benefit Period. Covered Services are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Contracting Provider.

6. Preventive Drugs

Covered Services are provided for those generic equivalent preventive drugs with a prescription, which as determined by the U.S. Preventive Services Task Force have a rating of A or B, in accordance with the Affordable Care Act of 2010. Generic equivalent preventive drugs with a prescription are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a participating pharmacy.

In order to receive Covered Services, the Participants must present the Prescription and First Priority Life Identification Card to a participating pharmacy and the claim must be filed by a participating pharmacy.

7. Nutritional Therapy

Nutritional therapy to promote a healthy diet is available to Participant, when provided by a licensed healthcare professional, up to the Maximum of six (6) visits per Participant per Benefit Period. Covered Services are exempt from all Deductibles, Coinsurance and Copayments, when provided by Contracting Providers.

Diabetes Outpatient self-management training and education as provided in the Description of Covered Service Section and Nutritional Therapy provided to a Homebound Participant under of the Description of Covered Services Section are exempt from this Benefit Maximum.

Coverage for dependent children, who are insured under the Agreement, will be provided as follows:

- Dependent children, ages two (2) through twelve (12), when accompanied by a parent.
- Dependent children, ages thirteen (13) through seventeen (17), with parental consent.

No coverage is provided for dependent children under the age of two (2).

BB. ALLERGY EXTRACTS/INJECTIONS

Covered Services are provided for allergy extracts and antigen injections.

CC. CHIROPRACTIC MANIPULATIVE COVERED SERVICES

For Participants age thirteen (13) and above, Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum of twenty (20) visits per Benefit Period, if Medically Necessary. No coverage is provided for Participant under the age of thirteen (13).

DD. DURABLE MEDICAL EQUIPMENT/PROSTHESES/ORTHOSES

Covered Services are provided for durable medical equipment, prostheses and orthoses when prescribed by a licensed health care professional. Except for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, replacements are not included, other than as certified as Medically Necessary for children due to normal growth process.

Instructions regarding appropriate use of the item are covered.

Covered Durable Medical Equipment includes, but is not limited to, the following:

a. hospital beds and related equipment (bed rails, mattresses);

b. equipment to increase mobility (walkers, wheelchairs);

c. commodes (elevated seats, portable bedside commodes);

d. breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);

e. therapeutic equipment;

f. apnea monitors;

g. Jobst pressure garments used in burn treatment; and

h. Unna boots and air casts.

Covered Prostheses and Orthoses include, but are not limited to, the following:

a. artificial limbs;

b. knee braces, not made of elastic or fabric support;

c. splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or “figure-8", finger, Pavlik harness and wrist);

d. immobilizers;

e. corrective shoes, shoe inserts and supports, and/or other foot Orthoses;

f. supportive back braces with metal stays;

g. dynasplints;

h. cryocuffs; and

Covered Services are not payable for dental appliances, wigs, or eyeglasses, except as specified in Description of Covered Services, Surgery.

EE. Covered Ostomy Supplies include and are limited to the following:

a. ostomy appliances and supplies specifically relating to an ostomy (colostomy, ileostomy, urostomy or tracheostomy) are limited to: collection devices, irrigation equipment and supplies, skin barriers and skin protectors.
b. urinary catheters, both reusable or disposable, whether or not used in conjunction with an ostomy.

Ostomy Supplies are covered as specified in Section SB – Schedule of Covered Services for Covered Medical Expenses up to a maximum of **$1 ,000** per Participants per Benefit Period or as indicated on ***the Outline of Coverage***. Coverage is limited to supplies obtained from Contracting Providers.

Supplies prescribed as a result of diabetes pursuant to Subsection X, Diabetes Education/Equipment/Supplies of this Description of Covered Service Section are excluded from this Covered Services.

Ostomy Supplies provided to a Participant pursuant to Subsection T, Home Health Care or pursuant to Subsection W, Hospice Care will not reduce this Covered Services.

FF. AUTISM SPECTRUM DISORDERS

The Outline of Coverage specifies Autism Spectrum Disorder coverage and how it applies. When Autism Spectrum Disorder coverage is applicable, refer to the following:

For Participants under twenty-one (21) years of age or as indicated on the ***Outline of Coverage***, coverage will be provided for the diagnostic assessment of Autism Spectrum Disorders and for the treatment of Autism Spectrum Disorders up to a Maximum Covered Services of **$36,000*** or as indicated on the ***Outline of Coverage*** per Participant per Benefit Period. Once the Benefit Period Maximum has been reached, no additional Covered Services are available under the agreement for the remainder of the Benefit Period for the diagnostic assessment and/or treatment of the Participant's Autism Spectrum Disorder. When a Provider renders Medical Care for treatment of a health condition unrelated to or distinguishable from the Participant's Autism Spectrum Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be applied toward this dollar Maximum.

No coverage is provided for Insured Persons age twenty-one (21) and over or as indicated on the ***Outline of Coverage***.

Treatment of Autism Spectrum Disorders shall be identified in a Treatment Plan for ASD and shall include any of the following Medically Necessary services: Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care, and Therapeutic Care that is:

i. Prescribed, ordered or provided by a licensed Physician, licensed Physician Assistant, licensed Psychologist, licensed clinical Social Worker, or certified Registered Nurse Practitioner.
ii. Provided by an Autism Service Provider.
iii. Provided by a person, entity or group that works under the direction of an Autism Service Provider.

The treatment plan should be developed by a physician or psychologist, following a comprehensive evaluation consistent with current recommendations of the American Academy of Pediatrics. The treatment plan may be reviewed once every six (6) months, subject to Blue Cross utilization review requirements, including case management, concurrent review and other managed care provisions. A more or less frequent review can be agreed upon by Blue Cross and the physician or psychologist developing the treatment plan. The provider is responsible for maintaining a copy of the autism assessment and treatment plan, to be made available upon request.

* After December 31, 2011, the Pennsylvania Insurance Commissioner shall publish in the Pennsylvania Bulletin an adjustment to the Autism Spectrum Disorder Maximum, equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U), to be applicable to the following Calendar Year. The Autism Spectrum Disorder Maximum shall be adjusted effective January 1 of the following Calendar Year.

The ***Outline of Coverage*** specifies whether Prescription Drug coverage applies.

HH. RETAIL CLINIC CARE

Covered Services are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient. Covered Services are provided for the examination, diagnosis, and treatment of common minor ailments.

II. EXPERIMENTAL OR INVESTIGATIVE SERVICES

A Medical Director of First Priority Life shall determine whether the use of any treatment, procedure, Provider, equipment, drug, device, or supply (each of which is hereafter called a "Service") is Experimental or Investigative (that is not supported by evidence-based medicine).

1. If, in making that determination, a Medical Director of First Priority Life finds that the service, for which a claim for Covered Services are made, is either: (1) the subject of a written investigational or research protocol used by the treating Provider or of a written investigational or research protocol of another Provider studying substantially the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental, Investigative, educational, or research; or (3) the subject of an on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative.

2. If, in making that determination, a Medical Director of First Priority Life finds that neither a protocol, an informed consent , nor an ongoing clinical trial, as described above, exist, then a Medical Director of First Priority Life may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:

a. the technology must have final approval from the appropriate governmental regulatory bodies;

b. the scientific evidence must permit conclusions concerning the effect of the technology on health

outcomes;

c. the technology must improve the net health outcome;

d. the technology must be as beneficial as any established alternatives; and

e. the improvement must be attainable outside the investigational settings.

PEER REVIEWED MEDICAL LITERATURE means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publication.

3. If, in making the determination, a Medical Director of First Priority Life finds that a drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is rendered; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the drug, device, supply or equipment shall be deemed to be Experimental or Investigative.

If the Participant's coverage includes Prescription Drug coverage, the Participant is responsible for the applicable Copayment, Coinsurance, and/or Deductible, if any, for each Prescription prescribed for the treatment of Autism Spectrum Disorder. The Copayment, Coinsurance, and/or Deductible, if any, are paid by the Participant directly to the Pharmacy for each Prescription. The ***Outline of Coverage*** specifies the Copayment, Coinsurance, and/or Deductible amounts.

The Outline of Coverage specifies if Prescription Drug coverage applies. When Prescription Drug coverage is applicable, refer to the following provisions.

PRESCRIPTION DRUG COVERAGE

A. DEFINITIONS

The following words and phrases when used in the Agreement shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. **COVERED PHARMACY EXPENSE** – A service or supply specified in the Agreement for which Covered Services for Prescription Drugs and supplies will be provided pursuant to the terms of the Agreement.

2. **DRUG FORMULARY** – A listing of Preferred Prescription Drugs and supplies covered by First Priority Life, which is subject to periodic review and modification at least annually by a committee of appropriate actively practicing preferred Physicians and Pharmacists. Prescription Drug inclusions in the Drug Formulary are based on a combination of criteria including clinical quality and cost effectiveness. The Participant will receive a copy of the Drug Formulary with the Certificate of Coverage. The Drug Formulary is available upon request from Express Scripts Service Representatives by calling toll-free 1-877-603-8399 or via First Priority Life's website, www.bcnepa.com.

3. **GENERIC EQUIVALENT PRESCRIPTION DRUG** – Any Prescription Drug that is considered to be therapeutically equivalent to other pharmaceutical equivalent products by the Food and Drug Administration, has received an "A Code" in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," and is in compliance with applicable state generic substitution laws and regulations.

4. **MAINTENANCE PRESCRIPTION DRUG** – Any Prescription Drug, not including Specialty Injectable Drugs, which First Priority Life makes available through a Participating Mail Order Pharmacy, which is generally used to treat chronic medical conditions and is generally not needed urgently for an immediate acute illness and which the Participant chooses to obtain, or First Priority Life requires be obtained, from a Participating Mail Order Pharmacy. First Priority Life may specify certain
Prescription Drugs that are not available through a Participating Mail Order Pharmacy.

5. **NON-PREFERRED PRESCRIPTION DRUG** – Any Prescription Drug listed in Tier 3 of the First Priority Life Drug Formulary available with a Tier 3 Copayment.

6. **PARTICIPATING COMMUNITY PHARMACY PROVIDER** – Any Participating Pharmacy Provider, which is a public, walk-in Pharmacy.

7. **PARTICIPATING MAIL ORDER PHARMACY PROVIDER** – A Participating Pharmacy, which has entered into a Participating Mail Order Pharmacy agreement with First Priority Life.

8. **PARTICIPATING PHARMACY PROVIDER** – Any Pharmacy, which has entered into a Participating Pharmacy agreement with First Priority Life or other entity contracted by First Priority Life to furnish a Pharmacy Provider network. Participating Pharmacy Providers include: Participating Community Pharmacy Providers, Participating Mail Order Pharmacy Providers and Participating Pharmacy Providers for Specialty Drugs.

9. **PARTICIPATING PHARMACY PROVIDER FOR SPECIALTY DRUGS –** A Participating Pharmacy Provider, which has entered into a Specialty Drug Provider Agreement with First Priority Life.

10. **PHARMACIST** – An individual who has been issued a license by the appropriate state licensing agency to engage in the practice of pharmacy, including the preparation and dispensing of Prescription Drugs and the dissemination of drug information to patients and health professionals.

11. **PHARMACY** – An establishment which has been issued a permit by the appropriate state licensing agency wherein the practice of pharmacy is conducted under the direct supervision and control of a licensed Pharmacist.

12. **PREFERRED PRESCRIPTION DRUG** – Any Prescription Drug, which is listed in the Drug Formulary and preferred by First Priority Life. Preferred Prescription Drugs are those listed in Tier 0, Tier 1 or Tier 2 of the Drug Formulary.

13. **PRESCRIBER** – An individual who has been issued a license by the appropriate state licensing agency to engage in a health care professional practice, who, acting within the scope of his/her license, is duly authorized by law to

prescribe Prescription Drugs.

14. **PRESCRIPTION** – An order from a Prescriber for a single Prescription Drug of a particular strength and/or dosage form.

15. **PRESCRIPTION DRUG** – Any medication, which by federal and/or state law may not be dispensed without a Prescription order issued by a Prescriber.

16. **PRESCRIPTION DRUG COINSURANCE –** The specific percentage of Covered Pharmacy expenses for which the Participant is responsible as set forth in ***the Outline of Coverage*** and in the ***Subsection B, Schedule for Covered Pharmacy Expenses***.

17. **PRESCRIPTION DRUG COINSURANCE MAXIMUM** – A specified dollar amount of Coinsurance that applies to Covered Pharmacy Expenses incurred by a Participant in a Benefit Period, as set forth in ***the Outline of Coverage***, and in the ***Subsection B, Schedule for Covered Pharmacy Expenses***.

18. **PRESCRIPTION DRUG COPAYMENT** – The amount a Participant must pay directly to Pharmacy Providers in connection with Covered Pharmacy Expenses as set forth in ***the Outline of Coverage***.

19. **PRESCRIPTION DRUG DEDUCTIBLE** – A specified amount of Covered Pharmacy Expenses, usually expressed in dollars as set forth in ***the Outline of Coverage*** that must be incurred by a Participant before First Priority Life will assume any liability for all or part of the remaining Covered Pharmacy Expenses.

20. **PRESCRIPTION DRUG MAXIMUM** – The greatest Covered Service amount payable by First Priority Life for Covered Pharmacy Expenses as set forth in ***the Outline of Coverage***.

21. **PRIOR AUTHORIZATION** – With regard to Prescription Drug Covered Services, Prior Authorization means the process whereby the Prescriber and/or the Participant is given prior approval by First Priority Life for certain Prescription Drugs, including Drug Formulary exceptions, and utilization review criteria, which have been designated by First Priority Life as requiring Prior Authorization.

22. **SPECIALTY DRUG** – Any Prescription Drug, which has been specifically designated by First Priority Life as being available from only a Participating Pharmacy for Specialty Drugs. Such Prescription Drugs classes include, but are not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech drugs. From time-to-time, such as when new biotech drugs become available, First Priority Life may specify certain Prescription Drugs that are available from only a Participating Pharmacy for Specialty Drugs.

B. SCHEDULE FOR COVERED PHARMACY EXPENSES

Except for special circumstances described in the following Subsection C, Prescription Drugs with Mail Order, Prescription Drugs dispensed by a non-participating Pharmacy are not covered. Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amount specified in ***the Outline of Coverage*** for one of the two options outlined below. Reimbursement will not exceed that set for the Generic Equivalent Drug. The difference in cost between the brand-name drug and the Generic Equivalent Drug will be payable by the Participant in addition to their Prescription Drug Copayment, Coinsurance and/or Deductible.

There may be a Copayment specific to self-administrable Prescription Drugs and supplies, excluding Specialty Drugs. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in ***the Outline of Coverage***. This Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Medical Expenses set forth in the Schedule of Covered Services for Covered Medical Expenses.

Based on ***the Outline of Coverage,*** there may be Prescription Drug Coinsurance for Specialty Drugs payable directly to the Participating Pharmacy Provider for Specialty Drugs. There maybe a **10%** Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of **$3,000** per Participant per Benefit Period. Once the Coinsurance Maximum is reached per Participant per Benefit Period, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period.

or

There may be a Prescription Drug Deductible per individual per Benefit Period as outlined in ***the Outline of Coverage*** for self-administrable Prescription Drugs and supplies, including Specialty Drugs.

Once the Prescription Drug Deductible is satisfied, there is a Copayment specific to self-administrable Prescription Drugs and supplies, excluding Specialty Drugs. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in ***the Outline of Coverage***. The Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Medical Expenses set forth above in the Schedule of Covered Services for Covered Medical Expenses.

Based on ***the Outline of Coverage,*** once the Prescription Drug Deductible is satisfied, there is Prescription Drug Coinsurance for Specialty Drugs payable directly to the Participating Pharmacy Provider for Specialty Drugs. There may be a **10%** Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of **$3,000** per Participant per Benefit Period. Once the Coinsurance Maximum is reached per Participant per Benefit Period, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period.

Unless otherwise stated, if the Participant's coverage does not include Prescription Drug coverage for each Prescription prescribed for the treatment of Autism Spectrum Disorder, there is a $0 Tier 0, $10 Tier 1, $25 Tier 2, and $45 Tier 3 Prescription Drug Copayment payable by the Participant directly to the Participating Pharmacy for each Prescription; there is a $0 Tier 0, $20 Tier 1, $55 Tier 2, and $135 Tier 3 mail order Prescription Drug Copayment payable by the Participant directly to the Participating Mail Order Pharmacy Provider.

C. PRESCRIPTION DRUGS WITH MAIL ORDER

Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified in the Outline of Coverage, as follows:

1. Covered drugs/supplies include: (a) Prescription Drugs which can be self-administered, including contraceptives for the use of birth control, ***if so specified in the Outline of Coverage,*** (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, sensors, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other drugs/supplies which may be specifically designated by First Priority Life, and (i) the covered pharmaceutical services necessary to make such drugs available, not including, however, any drug or group of drugs specifically excluded by the terms of the Agreement.
2. Reimbursement will not exceed that set for the Generic Equivalent Drug. The difference in cost between the brand-name drug and the Generic Equivalent Drug will be payable by the Participant in addition to their Prescription Drug Copayment.

   (a.) Each Prescription Drug is limited to a thirty (30) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature, and/or quantity limits allowed by First Priority Life.

   (b.) Each Maintenance Prescription Drug is limited to a ninety (90) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature, and/or quantity limits allowed by First Priority Life.
3. Prescriptions are refillable for a period not in excess of one (1) year from the date written and further subject to refill limitations as set forth in federal and/or state law or by the Prescriber.

4. Unless the Prescriber or Pharmacist has requested and received Prior Authorization for an early refill, the claim will be denied if a refill is requested before the time seventy-five (75) percent of the days' supply of medication has passed. An early refill Prior Authorization can be granted for an additional supply for reasons such as vacation or business travel. A Participating Pharmacy may receive authorization by telephone to fill the prescription early on a one-time-only basis any time before the next regular refill due-date.

In order to receive Covered Services, the Participant must present the First Priority Life Identification Card to a Participating

Pharmacy and the claim must be filed by a Participating Pharmacy, except in special circumstances and such other situations as deemed appropriate by First Priority Life. In special circumstances, such as when a Participant needs an unexpected Prescription when beyond a reasonable distance from a Participating Pharmacy, while vacationing or traveling out-of-area, inaccessibility to a Participating Pharmacy, inaccessibility of the First Priority Life electronic claims/eligibility systems, or for urgent or emergency needs, the Participant may request reimbursement for purchased Prescriptions from First Priority Life. Reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for the Generic Equivalent Drug, less the Copayment. If there is no Generic Equivalent Drug, reimbursement will not be in excess of the amount which would otherwise have been payable to a

5. Participating Pharmacy for a Preferred Prescription Drug, less the Copayment. Such requests are subject to a filing limit of one (1) year from the date of purchase.

6. All Prescription Drug claims are subject to prospective, concurrent and/or retrospective drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. Before prescribing the Prescription Drug, a Participating Prescriber will advise the Participant if Prior Authorization is required and request the Prior Authorization on behalf of the Participant. Participating Prescribers initially accept First Priority Life's determination of Medical Necessity. In the event the Prior Authorization is denied for lack of Medical Necessity, no Covered Services will be provided by First Priority Life when the Participant disregards the Prior Authorization denial and elects to purchase the Prescription Drug. Should a Prescription Drug, which requires Prior Authorization be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant prospectively that the claim was denied by First Priority Life because Prior Authorization is required for coverage of the Prescription Drug.

No Covered Services will be provided by First Priority Life when the Participant elects not to have the Participating Prescriber obtain Prior Authorization, disregards the Participating Pharmacy's notification of the claim denial and elects to purchase the Prescription Drug.

PRESCRIPTION DRUG EXCLUSIONS FOLLOW:

- Charges for any Prescription Drug or supply, which is not Medically Necessary and appropriate based on one (1) or more of the following reasons:
- The indication and/or use is of a cosmetic nature or to enhance physical appearance; to enhance athletic performance; or for weight loss.
- Based on the Pharmacist's professional judgment, the Prescription should not be dispensed.
- The Prescription Drug or supply is subject to Prior Authorization and has not been authorized as an exception, (based on, and supported by, medical justification from the Prescriber) for the following reason:
    - The use of the Prescription Drug or supply is contraindicated due to: overutilization, drug- drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, or drug allergy.
    - The use of the Prescription Drug or supply is subject by First Priority Life to utilization review criteria.
- ***The Outline of Coverage indicates whether contraceptives are covered.*** If contraceptives are not covered, coverage will not be provided for any Prescription Drug or supply including all dosage forms of contraceptives.
- Charges for any Prescription Drug or supply, unless authorized in accordance with the Agreement, which are:

    a. Experimental or Investigative.

    b. Not approved for use by the Food and Drug Administration.

    c. Not approved for the specific indication by the Food and Drug Administration.

d. Unless specifically included in Section DB – Description of Covered Services, the following are excluded as Covered Pharmacy Expenses:

(1) drugs which do not require a Prescription; (2) drugs which cannot be self-administered; (3) medical supplies; devices and equipment, (4) test agents and devices, except those used for diabetes; (5) smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by First Priority Life which are covered for one treatment period per lifetime; (6) multiple vitamins, except those used for pregnancy and multiple vitamins with fluoride for the prevention of dental caries in children under the age of sixteen (16); (7) injectable drugs used to treat infertility; (8) the additional charge for a brand-name drug for which there is a Generic Equivalent Drug available; (9) drugs for impotence in excess of four doses per month; (10) allergy extracts for allergen immunotherapy; (11) administration or injection of any drugs; (12) replacement of lost, stolen or damaged drugs; (13) take home drugs dispensed by a Facility Provider or Professional Provider.

Exhibit C - Managed Care Administrative Services Agreement
Exhibit D - Indemnity, Preferred Provider Organization or Comprehensive Major Medical Administrative Services Agreement

Complaint and Grievance Review Procedure

For Self-Funded Customers of BlueCross of Northeastern Pennsylvania, Highmark Blue Shield, First Priority Health and/or First Priority Life

The following procedures apply to all Administrative Services Agreement group products.

The self-funded health benefits program ("Plan") has a review and an appeal procedure. If any portion of an initial claim submission is not paid, there is a denial of services in whole or in part, or the Participant does not understand or agree with the handling of an initial claim determination or denial of services, there are several steps the Participant can take.

Many questions can be answered quickly calling the Customer Service number listed on the Identification Card of the Participant.

If the Participant is not satisfied with the handling of the claim after this step, the following procedures may be pursued:

If the Participant, or his/her dependents, have filed an initial claim for benefits and the claim is denied (in whole or in part), the Participant will be notified in writing, typically by an Explanation of Benefits or Notice of Certification, detailing the following:

- Specific reasons for the denial;
- Specific references to any provisions of the Plan under which the denial was made;
- The specific rule, guideline, protocol, or other similar criterion relied upon in making the decision or a statement that a copy of the rule, guideline, protocol, or other similar criterion is available upon request;
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances or a statement that such explanation will be provided free of charge upon request;
- A description of any additional material or information needed to perfect the claim with an explanation of why it is needed;

The Explanation of Benefits or Notice of Certification is provided to the Participant as an initial benefit determination.

The Participant may appeal the denial by filing a written or oral request (or oral request in the case of an urgent care claim) with BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE within 180 days after Participant receives the notice denying the initial claim for benefits. If Participant decides to appeal a denied claim for benefits, Participant will be able to submit written comments, documents, records, testimony, and other information relating to your claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE for review and consideration. Participant will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the appeal.

BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE will perform the following functions when an appeal is filed:

- Gather data related to the claim that may include the following information:
- Claims information
- Customer Service inquiries
- Referral or Precertification information
- Medical Policy Information
- Medical records
- Any additional information relied upon in making the decision

- When a denial is based on medical judgment, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall provide for a review of the claim by a health care professional that has appropriate training and experience in the field of medicine involved in the medicaljudgment.

BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE will respond to an appeal, withinthe following time periods:

- Post-Service Claim — In the case of an appeal of a denied post-service claim, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall respond to Participant within 30days after receipt of the appeal.
- Pre-Service Claim — In the case of an appeal of a denied pre-service claim, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall respond to Participant within 30days after receipt of the appeal.
- Expedited Pre-Service Claim — In the case of an appeal of a denied urgent care claims, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall respond to Participant within 72 hours after receipt of the appeal.
- Concurrent Care Review Claim — In the case of an appeal of a denied concurrent care review claims, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall respond to the Participant before the concurrent of ongoing treatment in question is reduced orterminated.

If BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE denies a claim (in whole or inpart), BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE will provide Participant withwritten notice of the denial (although initial notice of a denied urgent care claim may be provided toParticipant orally or via facsimile or other similarity expeditious means of communication). This notice willinclude the following:

- Reason for Denial — the specific reason for the denial;
- Reference to Plan Provisions — reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents — a statement that Participant is entitled to receive, upon request and free of charge, access to and copies of, all documents, records and otherinformation that is relevant to your claim and/or appeal for benefit;
- Description of Any Internal Rules — a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to Participant free ofcharge at your request; and
- Statement of Right to Bring Action — a statement that Participant is entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The Plan delegates to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE the authority to make determinations with respect to administrative services in regard to Covered Servicesunder the Plan on behalf of the Plan, and to provide benefits in accordance with BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE's medical policies. Such authority to apply the Plan rules and terms, to make factual determinations in connection with requests for benefits under the Plan, to determine what constitutes experimental or investigative services or supplies pursuant to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE's established policy, and to determine the medical necessity of providing benefits under the Plan.

Exhibit C - Managed Care Administrative Services Agreement
Exhibit D - Indemnity, Preferred Provider Organization or Comprehensive Major Medical Administrative Services Agreement

Complaint and Grievance Review Procedure

For Self-Funded Customers of BlueCross of Northeastern Pennsylvania, Highmark Blue Shield, First Priority Health and/or First Priority Life

BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall act as a fiduciary under the laws of the Commonwealth of Pennsylvania in connection with the exercise of its responsibilities regarding benefit determinations and reviews of denied claims for benefits under the Plan. BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE shall not be deemed a fiduciary for purposes of determining eligibility of persons for coverage under the Plan.

As provided for in the Summary Plan Description (SPD) or Plan Document, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE will review this information and make a final determination, as fiduciary, with regard to a denial of an initial claim or a denial of services, in whole or in part.

Final determinations denied on the basis of medical judgment are eligible for external review. The participant may file for an external review of the final determination by submitting a written request to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE. External review determinations will be made by a certified Independent Review Organization ("IRO"). External review is only available to those Plans which are not grandfathered as set forth in your Outline of Coverage.

The following is a list of procedures which BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE will follow if a request for External Review is submitted:

1. Receive external review request
2. Confirm external review eligibility
3. Collect documents from internal level review
4. Meet informally to review internal level case and any new information provided by member
5. Assign IRO
6. Contact member to inform of IRO assignment and right to refuse assignment
7. Prepare and forward documents to IRO
8. Carry out any actions resulting from IRO decision

The SPD is prepared and made available from the Participant's employer or through the entity that sponsors the self-funded medical Plan.

If the Participant is a member of an ERISA group, the Participant may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, once administrative remedies have been exhausted.