

KING'S

COLLEGE



WILKES-BARRE, PENNSYLVANIA 18711

KING'S COLLEGE

SUMMARY PLAN

DESCRIPTION

FIRST PRIORITY LIFE INSURANCE COMPANY
BLUECARE PPO 250 HEALTH PLAN

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WELCOME TO THE BLUECARE PPO PROGRAM

This Summary Plan Description is a summary of the Covered Services and main features of the BlueCare PPO 250 Health Plan provided by First Priority Life Insurance Company. Please reference the Summary Plan Description carefully to determine which health care services are covered.

ACTIVE EMPLOYEE PLAN

GROUP: #052598-000 (*ACTIVE*)
#052598-099 (*COBRA*)

Group Effective 07-01-2006
Benefit Schedule Effective 07-01-2007
Benefit Schedule Revised Effective 07-01-2008

The company office to contact about coverage is:

Contact: King's College
133 North River Street
Wilkes-Barre, PA 18711
Phone #: (570) 208-5962

First Priority Life Insurance Company mailing address, telephone and website are as follows:

Address: First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711
Customer Service Phone: 1-888-338-2211
Website: www.bcnepa.com

The Subscriber Number shown on my Identification Card is: _____

The "Effective Date" when my coverage begins is: _____

SECTION I: ADMINISTRATION OF THE PLAN

This booklet describes, in general, the main features of the Plan. Complete terms and conditions are set forth in the Agreement between First Priority Life Insurance Company and your Employer. The Plan is a partially self-funded Health Plan and the administration is provided through First Priority Life Insurance Company (FPLIC), 19 North Main Street, Wilkes-Barre, PA 18711.

The funding is derived from the funds of the Employer and contributions made by Employees, if applicable. The Plan is not insured.

This booklet has been prepared to meet the Summary Plan Description requirements of the Employee Retirement Income Security Act (ERISA) of 1974. The benefits provided under the Plan are subject to the terms and conditions of the group insurance contract issued by First Priority Life Insurance Company, 19 North Main Street, Wilkes-Barre, PA 18711.

Name of Plan

King's College
BlueCare PPO 250 Health Plan

Employer and Plan Sponsor

King's College

Plan Administrator

King's College
133 North River Street
Wilkes-Barre, PA 18711
(570) 208-5962

Claims Administrator

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711
1-800-822-8753

Employer Identification Number

24-0804602

Plan Number

513

Pre-Certification for Health Services

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711
1-800-822-8753

Pre-Certification for Mental Health Services

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711
1-800-577-3742

Participants

The benefits in this summary apply to Active Employees and COBRA participants of King's College.

Contributions

The Plan is funded by contributions made by the Employer and contributions made by the Employees, if applicable.

Plan Effective Date

07-01-2006
Revised 07-01-2007; Revised 07-01-2008

Named Fiduciary

King's College
133 North River Street
Wilkes-Barre, PA 18707
(570) 208-5962

Named Appeals & Grievance Fiduciary

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711
1-800-822-8753

Plan Records

The records for the Plan are reported on a contract year basis beginning July 1 through June 30.

Plan/Type Administration

The program described in this booklet is an Employee Welfare Plan providing Hospital, Medical-Surgical, and Prescription benefits administered by First Priority Life Insurance Company (FPLIC).

The benefits provided under this Plan and all statements in this booklet are subject to the terms and conditions of the Agreement between First Priority Life Insurance Company (FPLIC) and King's College.

Responsibilities for Plan Administration

Plan Administrator – King's College is the benefit Plan Administrator, also called the Plan Sponsor. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by King's College to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, King's College shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator

shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Services of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes that may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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.

Fiduciary

A fiduciary exercises discretionary authority or control over the following:

- Management of the Plan; or
- Disposition of its assets; or
- Renders investment advice to the Plan; or
- Responsibility in the administration of the Plan.

The named Fiduciary is King's College.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named Fiduciary" is the one named in the Plan. A named Fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named

Fiduciary allocates its responsibility to other persons, the named Fiduciary shall not be liable for any act or omission of such person unless either:

- The named Fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- The named Fiduciary breached its fiduciary responsibility under Section 405(1) of ERISA.

Claims Administrator Is Not a Fiduciary

The cost of the Plan is funded as follows:

- For Employee Coverage:
 - Funding is derived from the funds of the Employer and contributions made by the covered Employees.
- For Dependent Coverage:
 - Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Named Claims Administrator

The Claims Administrator for this Plan is First Priority Life Insurance Company (FPLIC). The address of the Claims Administrator's Customer Information Center is as follows:

First Priority Life Insurance Company
ATTN: Customer Service
19 North Main Street
Wilkes Barre, PA 18711

Effective Date

Effective Date of Employee Coverage- An Employee will be covered under this Plan as of the date that the Employee satisfies all of the following:

- The Eligibility Requirement.
- The Active Employee Requirement.
- The Enrollment Requirements of the Plan.

Active Employee Requirement – An Active Employee is a benefit eligible active Administration Employee or Support Staff Employee who works a minimum of thirty-five (35) hours or more each week on a consistent basis. A benefit eligible Active Faculty Employee who works the minimum hours or more each week on a consistent basis as outlined in the hiring contract. A benefit eligible active member of the Religious Orders who works the minimum hours or more each week on a consistent basis as outlined in the hiring agreements. An eligible grandfathered person with a separation agreement will be eligible for the benefits pursuant to the separation agreement.

Effective Date of Dependent Coverage- A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met within thirty-one (31) days of the event.

Complaint and Grievance Review Procedure

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 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 by 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.

First Priority Life Insurance Company provides administrative services only and do not assume any financial risk or obligation with respect to any claim for benefits.

The Participant may file for a review of the initial claim determination or denial of service with the claims Administrator, First Priority Life Insurance Company. First Priority Life Insurance Company will perform the following functions:

- Gather data related to the claim that may include the following information:
 - Claims information
 - Customer Service inquiries
 - Referral or Pre-certification information
 - Medical Policy Information
 - Medical records
 - Any additional information relied upon in making the decision
- When a denial is based on medical judgment, First Priority Life Insurance Company 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 medical judgment.

First Priority Life Insurance Company will forward this information to the named Fiduciary or named Plan Administrator of the Participant's self-funded Plan with a summary review of the initial claim determination.

As provided for in the Summary Plan Description (SPD), the named Fiduciary or named Plan Administrator of the self-funded Plan can 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 part.

If the Participant intends to request a review by First Priority Life Insurance Company or to formally appeal to the named Fiduciary or named Plan Administrator of the self-funded Plan a claim that has been

denied, it must be filed within the time frames specified in the Summary Plan Description (SPD). The Participant has the right to see all material relating to their claim and submit any comments or supporting documentation they wish for consideration.

As a Participant in 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.

Appeals of Initial Decisions

Within 180 days of receipt of an Adverse Determination, you or your duly authorized representative may petition the Claims Administrator in writing for a full and fair review of the denial. You or your duly authorized representative shall have the opportunity to review relevant documents and to submit issues and comments in writing, including documents, records and other relevant information to the Claims Administrator. For Urgent Care Claims, a request for an expedited appeal may be submitted orally or in writing and all information may be transmitted by telephone, facsimile or other similarly expeditious method.

Claims that are Incomplete or Improperly Filed

Incomplete Claims

If you file a claim that is incomplete because it does not provide enough information to make a determination as to whether or what extent benefits are covered, the following deadlines apply:

- Urgent Care Claims. The Plan will notify you of the incomplete claim and the specific information required to complete the claim within 24 hours of receiving the claim. You will then have 48 hours to provide the missing information. The Plan will then make a determination on the completed claim within 48 hours after the Plan's receipt of the missing information.
- Pre-Service Claims. The Plan will notify you of the incomplete claim and the specific information required to complete the claim within the initial 15 days the Plan has from the time it receives the incomplete claim. You will then have 45 days to provide the missing information. The Plan will then make a determination within 15 days after the Plan's receipt of the missing information.
- Post-Service Claims. The Plan will notify you of the incomplete claim and the specific information required to complete the claim within the initial 30 days the Plan has from the time it receives the incomplete claim. You will then have 45 days to provide the missing information. The Plan will then make a determination within 15 days after the Plan's receipt of the missing information.

Improperly Filed Claims

If you file an Urgent Care Claim or Pre-Service Claim improperly because it does not follow or satisfy the Plan's procedures for filing claims, the following deadlines apply (provided that the improper claim is received by a person or unit that customarily handles benefits matters and that it names a specific claimant, medical condition, and specific treatment, service or product for which approval is requested):

- Urgent Care Claims. The Plan will notify you of the improperly filed claim and the proper procedures required to file the claim within 24 hours of receiving the claim. Notification may be oral unless written notification is requested.
- Pre-Service Claims. The Plan will notify you of the improperly filed claim and the proper procedures required to file the claim within 5 days of receiving the claim. Notification may be oral unless written notification is requested.

Appeals Definitions

Adverse Determination includes any denial, reduction of or termination of, or failure to provide or pay for (in whole or in part) a benefit.

Concurrent Claim means a claim made where care has been approved and is being provided on an on-going basis for a period of time or for a certain number of treatments and the claim seeks to prevent a termination or reduction of this care.

Non-Urgent Care Claim means any group health plan claim that is not an Urgent Care Claim.

Post-Service Claim means any group health plan claim that is not a pre-service claim.

Pre-Service Claim means any claim for a benefit under a group health plan with respect to which the plan says you must get approval of the benefit in advance of obtaining medical care.

Urgent Care Claim means any claim that is necessary because the Non-Urgent Care Claim processing time "could seriously jeopardize the life or health of the claimant or the ability to regain maximum function." Physicians are allowed to make this determination.

Statement of ERISA Rights

The following statement of rights under ERISA is provided as required by regulation issued by the Department of Labor and is in the form suggested by the Department.

As a participant in your group insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides all Plan participants shall be entitled to:

Examine, without charge at the Plan Administrator's office and at other specified locations all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. This will be posted in a centralized location within King's College.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in anyway to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should

pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210.

Agent for Service of Legal Process on the Plan

King's College
133 North River Street
Wilkes-Barre, PA 18711
(570) 208-5962

Portability

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you terminate employment and obtain other health insurance coverage which has a pre-existing condition exclusion, you may be entitled to receive credit toward the exclusionary period, provided you have not had a break in coverage of more than 63 days.

Privacy of Health Information

Effective April 14, 2004, the receipt, use and disclosure of protected health information (PHI) is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain Employees working with, and on behalf of the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such disclosure. At the time you terminate coverage with us, First Priority Life Insurance Company will issue a certificate of coverage showing the period of time during which you were covered under this program. The new insurer will reduce its exclusionary period, if any, in accordance with that information and the HIPAA regulations.

Misrepresentations

If a false statement is intentionally made by the participant in obtaining coverage or benefits under this Agreement, or if the participant cooperates with a provider of service in the making of a false statement with the knowledge that such statement is false, this Agreement will be terminated immediately. Restitution will be sought by the Plan for any amounts paid to the subscriber or to a Provider because of any false statement or misrepresentation.

SECTION II: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

COBRA Continuation Options

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that employers with twenty (20) or more employees sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended

and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

NOTE: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance (TAA) under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

These employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the 6 months immediately after their group health plan coverage ended.

Any Employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA continuation coverage?

COBRA continuation coverage is group health plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated Non-COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is:

Any individual who on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or Dependent Child was a beneficiary under the Plan.

The term "covered Employee" refers to any individual who is provided coverage under the Plan due to his or her performance of services of the Employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or Dependent Child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A common law marriage partner, unless the common law couple was grandfathered under the sponsored plan, is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- The death of a covered Employee.
- The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- The divorce or legal separation of a covered Employee from the Employee's spouse.
- A covered Employee's enrollment in the Medicare program.
- A Dependent child ceasing to satisfy the Plan's requirements for a Dependent Child (e.g., attainment of the maximum age of 19, or the maximum age of 25 years of age while enrolled full time in college, or accredited secondary educational institution).
- A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.
- Leave of absence from being called to active military duty.

If the Qualifying Event causes the covered Employee, or the spouse or the Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date of the bankruptcy proceeding commences), the persons losing such coverage becomes Qualified Beneficiaries under COBRA if all the conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date, unless coverage is lost at a later date, and the Plan provides for the extension of the required period, in which case the maximum coverage date is measured from the date when the coverage is lost. Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last?

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualifying Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- A Dependent Child ceasing to be a Dependent Child under the generally applicable requirements of the Plan (e.g., attainment of the maximum age of 19, or the maximum age of 25 years of age while enrolled full time in college, or accredited secondary educational institution).
- The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation of coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event or the date the Qualifying Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualifying Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent (postmarked) to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusions or limitation with respect to any pre-existing

condition, other than such exclusions or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

- The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either Part A or Part B, whichever occurs earlier).

In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(i) 29 months after the date of the Qualifying Event or (ii) the first day of the month that is more than 30 days after the final determination under Title II or XVI of the Social Security Act that a disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement of the disability extension is no longer disabled, whichever is earlier; or

The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated Non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below.

In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension, and 29 months after the Qualifying Event if there is a disability extension.

In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

- 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
- 18 months (or 29 months if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

In the case of a bankruptcy Qualifying Event, the maximum coverage for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent Child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 30 months after the death of the retired covered Employee.

In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

In the case of an active military duty Qualifying Events, the maximum coverage period ends 24 months after the Qualifying Event.

In the case of any other Qualifying Events than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be extended?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is extended to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstances can the COBRA maximum coverage period be extended to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage?

Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be available in the absence of a disability extension. A group health plan can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Must the plan allow payments for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an Agreement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated Non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent (postmarked) to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficient and grants a reasonable period of time for payment of the deficient to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the requirement amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated Non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Conversion

If the subscriber ceases to be a participant for this program because of layoff, disability, leave of absence or termination of employment, arrangements may be made to continue coverage through BlueCross of Northeastern Pennsylvania under the direct payment type of participant Agreements. However, if a participant becomes one of a group having benefits available under a Health Insurance Program other than First Priority Life Insurance Company, he or she is not entitled to this conversion privilege.

If the participant dies, the surviving spouse and child may continue coverage under the direct payment type of subscriber Agreements. Children who reach the maximum age limit specified in the program also have the privilege of converting to the direct payment type of subscriber Agreements.

Continuation during Family and Medical Leave

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor. Leave taken under the Family Medical Leave Act shall be covered under this plan on the same conditions as previously provided, as though the Employee has been continuously employed up to the 12-week leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when the coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when the Plan coverage terminated.

What if I have more general COBRA questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Uniformed Services Employment And Reemployment Rights Act (USERRA)

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- 1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - a) The 24-month period beginning on the date on which the person's absence begins; or

- b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- 2) 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, if any, for the coverage.
- 3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

SECTION III: DEFINITIONS

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

ACTIVE FULL TIME EMPLOYEE – An Active Employee is a benefit eligible active Administration Employee or Support Staff Employee who works a minimum of thirty-five (35) hours or more each week on a consistent basis. A benefit eligible Active Faculty Employee who works the minimum hours or more each week on a consistent basis as outlined in the hiring contract. A benefit eligible active member of the Religious Orders who works the minimum hours or more each week on a consistent basis as outlined in the hiring agreements. An eligible grandfathered person with a separation agreement will be eligible for the benefits pursuant to the separation agreement.

ADJUNCTIVE PROCEDURES – Physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization.

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. 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.).

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 along with Deductibles, Coinsurance, Copayments, and amounts exceeding any Benefit Maximums, all of which are the responsibility of the Participant. 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 less. The Participant is liable for charges that exceed the Allowable Charge in addition to any Deductibles, Coinsurance, Copayments and Maximums, all of which are the responsibility of the Participant.

In the case of a Preferred Facility Provider, the Allowable Charge is established by a Provider Agreement with First Priority Life or the on-site Blue Cross and/or Blue Shield Licensee pertaining to payment for Covered Services and will be accepted by the Preferred Facility Provider as payment in full for Covered Services less any Deductibles, Coinsurance, Copayments, and Maximums, all of which are the responsibility of the Participant.

In the case of a Non-Preferred Facility Provider, the Allowable Charge is the average amount First Priority Life would pay to a Preferred Facility Provider in the First Priority Life PPO Network less any Deductibles, Coinsurance, Copayments, and Maximums, all of which are the responsibility of the Participant.

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, the

Accreditation Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to the Plan, 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.

ANNUAL OPEN ENROLLMENT PERIOD - A period of time, each Plan Year, when eligible Participants of the Plan may enroll with BlueCare PPO without a waiting period, exclusion, or limitation based on health status or, if already enrolled with BlueCare PPO, may transfer to an alternative health plan offered by the Employer.

BIRTHING FACILITY – A Facility Provider licensed or approved by the appropriate government agency, which is primarily organized and staffed to provide maternity care by Nurse Midwives.

BLUECARD – A program, which allows a Participant to access Covered Services from Providers located outside the geographic area serviced by First Priority Life which 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.

BLUECARD PPO NETWORK – A network of Providers located outside the geographic area serviced by First Priority Life who has a Provider Agreement with their on-site Blue Cross and/or Blue Shield Licensee.

BLUECROSS – BlueCross of Northeastern Pennsylvania, unless the context clearly indicates otherwise.

BLUECROSS PPO NETWORK – The BlueCare Network or any other Preferred Provider Organization (“PPO”) Network sponsored by Blue Cross.

BLUE SHIELD – Highmark Blue Shield, unless the context clearly indicates otherwise.

CALENDAR YEAR – A one (1) year period which begins on January 1 and ends on December 31.

CERTIFICATE OF COVERAGE – The documents provided to the Subscriber that provides evidence of the Subscriber’s coverage under the Contract and contains a statement of the essential features of the coverage. The BlueCare PPO Contract together with the Outline of Coverage comprise the Certificate of Coverage.

CERTIFIED REGISTERED NURSE – A certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing, or a national nursing organization recognized by the State Board of Nursing. This excludes any non-certified registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

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

CHIROPRACTIC – The use of Spinal Manipulation or Adjunctive Procedures in treating misaligned and displaced vertebrae or articulation and related conditions of the nervous system, provided that the licensee must be certified in accordance with Chiropractic Practice Act to use Adjunctive Procedures.

COINSURANCE – A specific percentage amount of the Allowable Charge or the Provider's Reasonable Charge, as applicable, for Covered Services set forth in the Schedule of Benefits, after the deduction of a Deductible or Co-payment, if applicable, to arrive at the amount for which the Subscriber is responsible.

COINSURANCE MAXIMUM – A specified dollar amount of Coinsurance incurred by a Subscriber, as set forth in the Schedule of Benefits, for Covered Services in a Contract Year. The Coinsurance Maximum does not include Coinsurance for ambulance and Outpatient mental health care, penalties for failure to obtain Pre-Certification, Deductibles, Co-payments, amounts in excess of the Allowable Charge, amounts in excess of the Provider's Reasonable Charge, or charges for non-Covered Services, charges after Covered Services have been exhausted, and any Deductible, Co-payment or Coinsurance amounts payable by the Subscriber for Covered Services under any Rider attached to this Contract.

CONTRACT – The agreement between the Plan and the Contract Holder, including all attachments, any riders and/or endorsements, if any, and the enrollment applications of the Subscribers are referred to as the Contract or the BlueCare PPO Contract.

CONTRACT HOLDER – An employer or organization sponsoring the Plan.

COPAYMENT – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth in the Benefit Schedule.

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

COVERED SERVICE – A service or supply specified in this Contract for which benefits will be provided pursuant to the terms of this Contract.

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 based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential, or place of service.

DEDUCTIBLE – A specified amount of Covered Services, expressed in dollars, that must be incurred by a Subscriber before the Plan will assume any liability for all or part of the remaining Covered Services.

DEPENDENT – The spouse of a Subscriber; or the Subscriber's or Subscriber's Spouse's unmarried child(ren) including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children covered under guardianship (legal documentation required).

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

DIAGNOSTIC SERVICES – The following procedures ordered by a Physician because of specific symptoms to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in Description of Benefits 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 ECG, EEG, and other diagnostic medical procedures approved by First Priority Life; and

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

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.

EFFECTIVE DATE – July 1, 2006

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

EMERGENCY CARE – The treatment of a medical condition with acute symptoms of severity or severe pain for which:

- a. care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and
- b. the absence of immediate medical attention could result in:
 - (i.) placing health in serious jeopardy;
 - (ii.) Serious impairment to bodily functions;
 - (iii.) Serious dysfunction of any body part; or
 - (iv.) Other serious medical consequences.

EMPLOYEE – An individual who performs services in the regular course of the business of the Contract Holder, is considered full time, as defined by the Contract Holder, 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. The term employee also includes persons eligible to enroll in a bona-fide Taft-Hartley Health and Welfare Plan.

EXPERIMENTAL/INVESTIGATIVE – The use of any treatment, procedure, facility, equipment, drug, device or supply that is determined to be:

- 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 1 & 2 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

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

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

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

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

HOME HEALTH CARE AGENCY – A Facility Provider, which:

- a. provides skilled nursing and other services on a visiting basis in the Subscriber's home; and
- b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

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.

HOME INFUSION THERAPY AGENCY – A Facility Provider, which provides Home Infusion Therapy and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the patient's Physician.

HOMEBOUND – A Member 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 Members should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.

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

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 Insured's Physician.

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 by the Plan, 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 treatment of alcoholism or drug abuse,

- Place for the provision of Hospice care, or
- Place for the provision of rehabilitation care.

IDENTIFICATION CARD/CARD CARRIER – The currently effective card that entitles a Participant to receive Covered Services under the terms of the Plan.

IMMEDIATE FAMILY – The Subscriber's spouse, parent, brother, sister, other-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child or step-child.

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

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 the Plan and which provides services that are necessary for short-term evaluation, diagnosis, and treatment (or crisis intervention) of Serious Mental Illness.

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.

INPATIENT NON-HOSPITAL RESIDENTIAL FACILITY – A Facility Provider licensed by the Department of Health to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care.

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

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 program duration greater than sixty (60) days. Long-Term Residential Care is not Inpatient Non-Hospital Residential Care.

MASTECTOMY – Removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

MAXIMUM – The greatest benefit amount payable by the Plan for Covered Services. This could be expressed in dollars, number of days, or number of services for a specified period of time, as set forth in the Schedule of Benefits.

- a. **Benefit Maximum** – the greatest benefit amount payable by the Plan for a specific Covered Service, per Calendar Year.
- b. **Lifetime Benefit Maximum** – the greatest benefit amount payable by the Plan for a specific Covered Service, in the Subscriber's lifetime.

MEDICAL CARE – Services rendered by a Professional Provider for the diagnosis and treatment of an illness or injury.

MEDICAL EMERGENCY – A medical condition with acute symptoms of severity or severe pain for which:

- a. care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and
- b. the absence of immediate medical attention could result in:
 - (i.) placing health in serious jeopardy;
 - (ii.) Serious impairment to bodily functions;
 - (iii.) Serious dysfunction of any body part; or

(iv.) Other serious medical consequences.

MEDICALLY NECESSARY (or Medical Necessity) – Services or supplies provided by a Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Subscriber's condition, illness, disease, or injury;
- b. provided for the diagnosis or the direct care and treatment of the Subscriber's condition, illness, disease, or injury;
- c. in accordance with the standards of good medical practice;
- d. not primarily for the convenience of a Subscriber or the Provider; and
- e. the most appropriate supply or level of service that can safely be provided to the Subscriber.

When applied to hospitalization, this further means that the Subscriber requires acute care as a bed patient due to the nature of the services provided or the Subscriber's condition, and the Subscriber cannot receive safe or adequate care as an Outpatient or in another less costly setting.

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

MEMBER – A Subscriber or Dependent as defined in this Section.

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

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

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

NON-HOSPITAL ALCOHOL OR DRUG ABUSE FACILITY - A facility, licensed by the Department of Health, for the care or treatment of alcohol or other drug dependent persons, except for transitional living facilities.

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

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.

OUTLINE OF COVERAGE – A document provided to the Subscriber, which specifies the benefits of the Plan.

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

PARTIAL HOSPITALIZATION - The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled Outpatient basis through a Hospital or non-Hospital facility licensed as a mental health or Alcohol and/or Drug Abuse treatment program by the Pennsylvania Department of Health, 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.

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 its branches, perform Surgery and prescribes drugs.

PREFERRED PROVIDER AGREEMENT – An agreement between a Preferred Provider and Blue Cross or any other Blue Cross and/or Blue Shield Licensee pursuant to which negotiated rates are established for payment of Covered Services rendered to a Member.

PRE-CERTIFICATION – The process whereby a Provider or Subscriber, as applicable, is required to obtain certification from the Plan for Covered Services prior to the date of service. Pre-Certification will result in the issuance of a Pre-Certification number or approval by the Plan, without which the claim may not be paid. The Plan 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 Contract Holder and Subscriber at the address on the records of the Plan at least thirty (30) days in advance of such change.

PREFERRED PROFESSIONAL PROVIDER ALLOWANCE – A schedule of allowances or payment methodology as approved by the Insurance Department of the Commonwealth of Pennsylvania. In this Contract, the Preferred Professional Provider Allowance is that approved for use with the Premier Blue Preferred Provider Program.

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.

PROSTHETIC DEVICES – Use of initial and subsequent artificial devices to replace the removed breast or portions thereof pursuant to an order of the patient's physician.

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

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 Preferred Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and/or is a member of the BlueCard PPO Network.
- **PREFERRED FACILITY PROVIDER** – A Facility Provider that has a Provider Agreement with First Priority pertaining to payment for Covered Services rendered to a Participant as a member of the First Priority Life PPO Network, or a member of the BlueCard PPO Network. When the First Priority PPO Network or the BlueCard PPO Network is used by Participants of this Agreement, coverage will be provided at the Preferred Provider Level. A Preferred Facility Provider is also known herein as a Participating Facility Provider.
- **PREFERRED PROFESSIONAL PROVIDER** – A Professional Provider who has an agreement with Highmark Blue Shield and/or First Priority Life pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider Program or a Professional Provider who is a member of the BlueCard PPO Network.
- **NON-PREFERRED PROVIDER** – 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 BlueCard PPO Network.
- **NON-PREFERRED FACILITY PROVIDER** – A Facility Provider that is not in the First Priority Life PPO Network or the BlueCard PPO Network, and does not have a Provider

Agreement with First Priority Life or an on-site Blue Cross and/or Blue Shield Licensee. A Non-Preferred Facility Provider is also known herein as a Non-Participating Facility Provider.

- **NON-PREFERRED PROFESSIONAL PROVIDER** – A Professional Provider who does not have a Provider agreement with First Priority Life and/or Highmark Blue Shield pertaining to payment for Covered Services rendered to a Participant enrolled in a Preferred Provider Program, or a Professional Provider who is not a member of the BlueCard PPO Network.

PROVIDER AGREEMENT – An agreement between a Provider and First Priority Life or any other Blue Plan participating in BlueCard pursuant to which negotiated rates are established on a participating provider basis for payment of Covered Services rendered to a Participant.

PROVIDER'S REASONABLE CHARGE – For Preferred and Non-Preferred Professional Providers in Pennsylvania, the Provider's Reasonable Charge is based upon the Preferred Professional Provider Allowance as defined in this Contract or the charge, whichever is lower. For out-of-state Preferred Professional Providers who are members of the BlueCard PPO Network, the Provider's Reasonable Charge will be determined by the contract between the on-site Blue Cross and/or Blue Shield Licensee and the Professional Provider and will be accepted by the Professional Provider as payment-in-full for Covered Services less any Deductibles, Coinsurance, Co-payments and Maximums, all of which are the responsibility of the Subscriber. For Covered Services performed out-of-state by Non-Preferred Professional Providers, the Provider's Reasonable Charge will be based on the 90th percentile of actual charge data that Blue Shield has accumulated for the state in which the services were performed. Payment is based upon the Providers Reasonable Charge or the charge, whichever is lower. The Subscriber is liable for charges that exceed the Provider's Reasonable Charge in addition to any Deductibles, Coinsurance, Co-payments and Maximums, all of which are the responsibility of the Subscriber.

PSYCHIATRIC HOSPITAL – A Facility Provider, approved by the Joint Commission on the Accreditation of Healthcare Organizations, or a similar accrediting agency acceptable to the Plan, 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.

PSYCHOLOGIST – A licensed clinical Psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

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.

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.

REHABILITATION HOSPITAL – A Facility Provider, approved by the appropriate accrediting agency, 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.

RESPIRE 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.

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.

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.

SERVICE AREA – For Professional Providers, Other Providers, and Suppliers, the Service Area is the Commonwealth of Pennsylvania; for Facility Providers, the Service Area is thirteen Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming; and the licensed Service Area is also these thirteen Pennsylvania counties.

SKILLED NURSING FACILITY – A Facility Provider, which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in a Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- a. minimal care, Custodial Care, ambulatory care, or part-time care services;
- b. care or treatment of mental illness, alcoholism, drug abuse or pulmonary tuberculosis; or
- c. care or treatment for the blind, the deaf or the mentally deficient or retarded.

SPINAL MANIPULATION – Treatment or correction of the spine by use of the hands only. Other terms for Spinal Manipulation include the following: spine or spinal adjustment by manual means; manual manipulation; manual adjustment; and vertebral manipulation or adjustment.

SUBSCRIBER – A person who meets all applicable eligibility requirements and has enrolled with the Plan. A Subscriber is also a Member.

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.

SUBSTANCE ABUSE TREATMENT FACILITY – A Facility Provider, approved by the Department of Health, which is primarily engaged in Detoxification and/or rehabilitation treatment for Alcohol and/or Drug Abuse.

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

SURGERY -

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

THERAPY SERVICES – The following services or supplies ordered by a Physician and used for the treatment of an illness or injury to promote the recovery of the Subscriber. Therapy Services are covered to the extent specified in the Schedule of Benefits and benefit sections.

- 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 for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

d. **Occupational Therapy** - 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-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

f. **Pulmonary Rehabilitation Therapy** -- A program of exercise training, psychological support and 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, radium, or radioactive isotopes.

h. **Respiratory Therapy** - Introduction of dry or moist gases into the lungs for treatment purposes.

i. **Speech Therapy** - Treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

TOTAL DISABILITY – The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment. During the entire period of Total Disability, the Employee or Dependent may not be engaged in any activity whatsoever for wage or profit and must be under the regular care of a physician. If the person does not usually engage in any occupation for wages or profit, "Total Disability" means that he/she has a medically determinable physical or mental impairment, which results in marked and severe functional limitations and is substantially unable to engage in the normal activities of an individual of the same age and sex.

TRANSITIONAL LIVING FACILITY – A facility that renders Long-Term Residential Care. This type of facility can be licensed, when appropriate, by the 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.

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

SECTION IV: ELIGIBILITY

OPEN ENROLLMENT

During the Annual Open Enrollment Period, eligible Participants of the Plan may enroll with BlueCare PPO without a waiting period, exclusion, or limitation based on health status or, if already enrolled with BlueCare PPO, may transfer to an alternative health plan offered by the Employer.

Benefit choices made during the Annual Open Enrollment Period will become effective July 1 of the next Plan Year and remain in effect through the Plan Year unless there is a change in family status during the Plan Year. Changes in family status events include the following:

- Birth
- Death
- Adoption
- Marriage
- Divorce

- Spouse's Loss of coverage due to loss of employment

A Participant who does not elect a change during Annual Open Enrollment Period will automatically retain his/her present coverage.

Participants will receive detailed information regarding Annual Open Enrollment Period from the Employer.

During Annual Open Enrollment Period, a Dependent's coverage will take effect on July 1 of the next plan year, provided the Eligibility Requirements are met; the Participant is covered under the Plan; and all Enrollment Requirements are met within thirty-one (31) days of July 1.

ELIGIBILITY

Newly hired Active Full Time Employees and their eligible Dependents will be eligible for the benefits described in the Summary Plan Description on the first of the month following completion of the required 30-day Probationary Period. An eligible grandfathered person with a separation agreement will be eligible for the benefits pursuant to the separation agreement.

Persons who become eligible Dependents of an enrolled Employee after the effective date of the Employee's enrollment will be eligible for these benefits upon notification from the Employee of such additional Dependents to the Plan Sponsor. This must be completed within thirty-one (31) days of the event. Failure to do so will result in the Employee being required to wait until the Annual Open Enrollment Period to add the Dependent. An eligible Employee must enroll for coverage by filling out and signing an enrollment application. The covered eligible Employee is required to enroll for Dependent Coverage by filling out and signing an enrollment application also.

At the direction of the Plan, to be eligible to enroll as a Dependent, a person must be:

- a) The spouse; or
- b) the Participant's or Participant's Spouse's unmarried child(ren) including: newborn children, stepchildren, children legally placed for adoption, legally adopted children, handicapped individuals and children covered under court order (legal documentation may be required).

Each eligible Dependent Child Participant is covered from birth until: (a) the end of the calendar year in which he reaches his 19th birthday, (b) the end of the month in which he marries, becomes employed full time, discontinues Full Time Student status or ceases to be an eligible dependent. Eligibility shall continue past the limiting age for unmarried children who are unable to work to support themselves due to mental retardation, physical handicap, Mental Illness, or developmental disability if such disability commenced while the child was a validly enrolled Dependent on the parent's policy; the child has been continuously enrolled since the commencement of the disability and has been certified as disabled by the Plan.

Unmarried Dependent Full Time Student Participants will be covered to end of the calendar year in which they turn age 25, provided they maintain Full Time Student status. If the unmarried Dependent Full Time Student Participant discontinues Full Time Student status any time between the ages of 19 and 25, the coverage will end the last day of the month in which the Full Time Student status is discontinued.

At the direction of the Plan, coverage of a newborn child of a Participant, a newborn adopted child of a Participant or a newborn child placed for adoption of a Participant is effective at the time of birth and shall automatically extend for a period of thirty-one (31) days following birth. The adoptive child shall be treated the same as any other Dependent under the Agreement. Coverage shall include sickness or injury, including medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care.

The Participant shall have the right, within the thirty-one (31) day period following the birth of the newborn child, to continue coverage for the child beyond the thirty-one (31) day period by enrolling the newborn

child as a Dependent with the Plan. The covered eligible Employee is required to enroll the newborn child by filling out and signing an enrollment application within the thirty-one (31) day period.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you, as a parent, to cover a child who is not in your custody, you may do so. To be qualified, a Qualified Medical Child Support Order must include:

- Name and last known address of the parent who is covered under this Plan;
- Name and last known address of each child to be covered under this Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSO's should be sent to the Plan Administrator. The Plan Administrator will notify you of the acceptance or denial of the order. If the order is qualified, your Child(ren) will be enrolled under the Plan. As a beneficiary covered under the Plan, your Child(ren) will be entitled to information that the Plan provides to other beneficiaries.

TERMINATION OF COVERAGE

When coverage under this Plan stops, covered Participants will receive a (HIPAA) Certificate of Coverage that will show the period of coverage under this Plan from First Priority Life Insurance Company.

When Employee Coverage Terminates- Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

- The date the Plan is terminated.
- The last day of the calendar month in which the covered Employee ceases to be eligible. This includes death or termination of Active Employment of the covered Employee.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due, if applicable.

When Dependent Coverage Terminates- A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Option):

- The date the Plan is terminated.
- The date the Dependent's coverage is terminated.
- The date that the Employee's coverage under the Plan terminates for any reason including death.
- The date a covered Spouse loses coverage due to a loss of dependency status.
- On the last day of the calendar year that a Dependent child ceases to be a Dependent as defined by the Plan.
- On the last day of the month in which a Dependent child ceases to be a Full Time Student, marries or becomes employed full time.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

MEDICARE ELIGIBILITY OR ENTITLEMENT:

Working Aged

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 was designed to make Medicare the secondary payer for certain Employees and Dependents. Under the TEFRA law and subsequent legislation, the Group Health Plan is the primary payer and Medicare is the secondary payer of claims for working aged Employees and certain Dependents in employer groups with twenty (20) or more full-time and/or part-time Employees. Medicare is the primary payer for working aged Employees and certain Dependents in employer groups with less than twenty (20) full-time and/or part-time Employees. Employers, who do not meet the criteria of having twenty (20) or more full-time and/or part-time Employees, may offer a group Medicare Supplement Policy (MSP), BlueCare Senior, to their working aged Employees and Dependents who are Medicare beneficiaries. BlueCare Senior will require the working aged Employee and certain Dependents who are Medicare beneficiaries to enroll in Medicare Part B.

Working aged are beneficiaries age sixty-five (65) or over who have Group Health Plan (GHP) coverage because of their current employment or their spouse's current employment. For the working aged, Medicare is secondary payer for claims to the GHP. For the purposes of the MSP Working Aged provision, a GHP is any health plan that is for, or contributed to by, an employer of twenty (20) or more Employees that provides medical care, directly or through other methods, such as insurance or reimbursement, to current or former employees and their families.

The "20 or more employees" threshold is met when an employer has twenty (20) or more full-time and/or part-time employees for each working day in each of twenty (20) or more calendar weeks in the current Calendar Year or the preceding calendar year. The twenty (20) calendar weeks do not have to be consecutive. The requirements of the MSP Law are based on the number of employees, not the number of individuals covered under the plan.

Disability

The Omnibus Budget Reconciliation Act of 1993 (OBRA) made the Group Health Plan the primary payer and Medicare the secondary payer for certain claimants who are Medicare beneficiaries because of disability in Employee Groups with one hundred (100) or more full-time and/or part-time Employees. Medicare is the primary payer for certain claimants who are Medicare beneficiaries because of disability in Employee Groups with less than one hundred (100) full-time and/or part-time Employees. Employers, who do not meet the criteria of having one hundred (100) or more full-time and/or part-time Employees, may offer a group Medicare Supplement Policy, BlueCare Senior, to their disabled Employees and Dependents who are Medicare beneficiaries because of disability. BlueCare Senior will require the disabled claimants who are Medicare beneficiaries to enroll in Medicare Part B.

Medicare is secondary payer for claims for beneficiaries under age sixty-five (65) who have Medicare because of a disability and who are covered under a large group health plan (LGHP) through their current employment or through the current employment of any family member. A GHP that covers Employees of at least one employer that had one hundred (100) or more Employees on fifty (50) percent or more of its business days during the preceding Calendar Year meets the definition of an LGHP. The Large Group Health Plans (LGHP) include plans sponsored or contributed to by an employer or employee organization (such as a union), as well as plans in which employees pay all the costs. The plan provides health care to Employees, former Employees, the employer, or their families, and covers at least one hundred (100) or more full-time and/or part-time Employees.

End Stage Renal Disease (ESRD)

The Balanced Budget Act of 1997 (BBA 1997) made the Group Health Plan the primary payer and Medicare the secondary payer in the case of individuals eligible for or entitled to Medicare benefits on the basis of ESRD during a thirty (30) month coordination period. Medicare is the primary payer

following the thirty (30) month coordination period. Following the coordination period, employers may offer a group Medicare Supplement Policy, BlueCare Senior, to individuals who are Medicare beneficiaries on the basis of ESRD. BlueCare Senior will require such individuals who are Medicare beneficiaries to enroll in Medicare Part B.

ACT 83 OF 2005- STUDENT DEPENDENTS IN THE ARMED FORCES:

Eligibility shall be extended to Full-Time Students who remain eligible for coverage as dependent children under this Contract and who are members of the Pennsylvania National Guard or any reserved component of the armed forces of the United States and called or ordered to active duty or to active State duty, other than active duty for training, for a period of thirty (30) or more consecutive days. The extension of eligibility for such Full-Time Students shall be for a period equal to the duration of the eligible Member's service or active duty or active state duty or until the eligible Member is no longer a Full-Time Student provided, the eligible Member submits to the Plan forms approved by the Department of military and Veterans Affairs:

1. Notifying the Plan that the eligible Member has been placed on active duty;
2. Notifying the Plan that the eligible Member is no longer on active duty; and
3. Showing that the eligible Member has re-enrolled as a Full-Time Student for the first term or semester starting sixty (60) or more days after the Member's release from active duty.

SECTION V: COVERED SERVICES

A Participant is entitled to Covered Services provided in the Covered Services sections during a Benefit Period, subject to the Deductible, Copayment and Coinsurance, if any, and in the amounts as specified by the Plan. For services, which are not provided by a Preferred Provider, the Participant will be penalized by the application of a higher Coinsurance level.

COVERED SERVICES		
BENEFIT PERIOD : Calendar Year		
PLAN ADMINISTRATION	PREFERRED	NON-PREFERRED
INDIVIDUAL DEDUCTIBLE: Individual Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.		
INDIVIDUAL DEDUCTIBLE LEVEL	\$250 Maximum Per Benefit Period	\$500 Maximum Per Benefit Period
FAMILY DEDUCTIBLE: Maximum three (3) separate deductibles per family. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.		
FAMILY DEDUCTIBLE LEVEL	\$750 Maximum Per Benefit Period	\$1,500 Maximum Per Benefit Period
COINSURANCE: Coinsurance applies to all Covered Services, except Outpatient Emergency Accident/Medical services, Outpatient Medical Care and those services specifically prohibited by law.		
COINSURANCE LEVEL	90% Plan 10% Member	70% Plan 30% Member
COINSURANCE MAXIMUM PER PERSON: Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.		
COINSURANCE MAXIMUM PER PERSON LEVEL	\$2,500 Maximum Per Benefit Period	\$5,000 Maximum Per Benefit Period
COINSURANCE MAXIMUM PER FAMILY: Maximum three (3) separate coinsurance maximums per family, per Benefit Period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred		
COINSURANCE MAXIMUM PER FAMILY LEVEL	\$7,500 Maximum Per Benefit Period	\$15,000 Maximum Per Benefit Period
LIFETIME MAXIMUM	Unlimited	\$1,000,000 per lifetime, per Participant.
PRECERTIFICATION PENALTY	Not Applicable	\$500
PRIMARY CARE OFFICE VISITS	\$15	After Deductible 70% Plan 30% Member
PRIMARY CARE OFFICE VISITS: Unlimited Visits, unless otherwise noted. Preferred coverage not subject to Deductible. Non-Preferred is subject to the deductible.		
SPECIALTY CARE OFFICE VISITS	\$15	After Deductible 70% Plan 30% Member
SPECIALTY CARE OFFICE VISITS: Unlimited Visits, unless otherwise noted. Preferred coverage not subject to Deductible. Non-Preferred is subject to the deductible.		

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
AMBULANCE		
Ambulance Emergency Transport	80% Plan 20% Member Not Subject to Deductible	80% Plan 20% Member Not Subject to Deductible
Ambulance Non-Emergency Transport	After Deductible 80% Plan 20% Member	After Deductible 80% Plan 20% Member
ANESTHESIA		
Administration of anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Pre-certification Penalty – Failure to initially obtain Pre-certification for a Non-Preferred Professional Provider services will result in a reduction in the professional Covered Services payable for anesthesia services.	N/A	\$500 Facility 50% Plan 50% Member
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.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Pre-certification Penalty – Failure to initially obtain Pre-certification for a Non-Preferred Professional Provider services will result in a reduction in the professional Covered Services payable for Assistant Surgeon services.	N/A	\$500 Facility 50% Plan 50% Member
BLOOD		
Blood	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
CHIROPRACTIC CARE		
For participants age thirteen (13) and above, Chiropractic Covered Services, including Spinal Manipulation and Adjunctive Procedures. Chiropractic Care is limited to Eighteen (18) visits per Benefit Period. No coverage is provided for Participants under the age of thirteen (13).	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
CONCURRENT CARE		
Concurrent Care	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
CONSULTATIONS		
Consultations are limited to one (1) per consultant during any one (1) Inpatient stay.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
DIABETES EDUCATION PROGRAM		
Diabetes Education Program	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
DIAGNOSTIC SERVICES – OUTPATIENT		
Diagnostic Radiology, Diagnostic Pathology, Diagnostic Medical and Allergy Testing.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
DURABLE MEDICAL EQUIPMENT, ORTHOTICS, AND PROSTHETICS		
Coverage is provided for a combined benefit up to \$2,500 Max. per Benefit Period, except Prosthetics prescribed as result of a Mastectomy or Orthotics prescribed as a result of diabetes are excluded from this limit.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
EMERGENCY ACCIDENT/ EMERGENCY MEDICAL CARE SERVICES		
Treatment and services in the Outpatient department of a Hospital. *Copayment will be waived if participant is admitted as result of the emergency.	After \$100 Emergency Room *Copayment 100% Plan Not Subject to Deductible	After \$100 Emergency Room *Copayment 100% Plan Not Subject to Deductible
HIGH TECH IMAGING		
High Tech Imaging (MRI, MRA,CT,PET Scans, Nuclear Cardiology)	After Deductible and \$75.00 Copayment 100% Plan	After Deductible 70% Plan 30% Member
HOME HEALTH CARE		
Unlimited visits per Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Failure to Pre-certify services in a Non-Preferred Facility Provider or Preferred Facility Provider outside First Priority Life Insurance Company Service Area will result in a reduction of Covered Services payable for these services.	N/A	\$500 Facility 50% Plan 50% Member
HOME INFUSION THERAPY		
Home Infusion Therapy	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
HOSPICE CARE		
Maximum coverage for one-hundred eighty (180) days per Lifetime. <ul style="list-style-type: none"> • Thirty (30) inpatient days (included in the 180 lifetime days); • Respite Care: Five (5) days every Three (3) Months, Maximum Ten (10) days per lifetime; • Bereavement counseling (limited to two (2) visits). 	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
INFERTILITY TREATMENT		
Infertility Treatment	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Invitro-Fertilization	Not Covered	Not Covered
Artificial Insemination (3 attempts per lifetime)	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Voluntary Sterilization (reversals not covered)	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Non-elective abortion	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
INPATIENT HOSPITAL CARE		
Services and supplies provided. Unlimited days per Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Inpatient services and supplies provided as a result of an accident or Medical Emergency.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Pre-certification Penalty – Failure to initially obtain Pre-certification to a Non-Preferred Facility Provider or Preferred Facility Provider outside the First Priority Life Insurance Company. Service Area will result in a reduction in Covered Services payable for Inpatient Hospital service.	N/A	\$500 Facility 50% Plan 50% Member
INPATIENT REHABILITATION		
Inpatient Services: Maximum forty Five (45) days per Benefit Period	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
MATERNITY SERVICES		
Maternity Services: Copayment for initial office visit only; Initial visit \$15. Neonatal circumcision is covered.	After Copayment 90% Plan 10% Member	After Deductible 70% Plan 30% Member
MENTAL HEALTH CARE		
Inpatient Facility Services:		
An aggregate total of thirty (30) days per Benefit Period will be provided for admissions for Serious Mental Illness (SMI) and for other Mental Illness, except that any claims for other Mental Illness will not reduce the thirty (30) days available for Serious Mental Illness (SMI) during a Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
The thirty (30) day Inpatient Covered Service can be converted to Partial Hospitalization Psychiatric Care. Every two (2) days used shall reduce by one (1) day the number of Inpatient days available during the Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Failure to Pre-certify services in a Non-Preferred Facility Provider or Preferred Facility Provider outside the First Priority Life Insurance Company Service Area for Inpatient or Partial Hospitalization Psychiatric Care Services will result in a reduction in Covered Services payable for such services.	N/A	\$500 Facility 50% Plan 50% Member
Inpatient Professional Services:		
An aggregate total of thirty (30) visits per Benefit Period will be provided for admissions for Serious Mental Illness (SMI) and for other Mental Illness, except that any claims for other Mental Illness will not reduce the thirty (30) visits available for Serious Mental Illness (SMI) during a Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
The thirty (30) visit Inpatient Covered Services can be converted to Outpatient professional visits. Every two (2) visits shall reduce by one (1) visit the number of Inpatient visits available during the Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Outpatient Services:		
An Aggregate total of sixty (60) visits for Outpatient Facility and/or Outpatient Professional Services will be provided during a Benefit Period for Serious Mental Illness and for other Mental Illness, except that any claims for other Mental Illness will not reduce the sixty (60) visits available for Serious Mental Illness during a Benefit Period.	After Deductible 50% Plan 50% Member	After Deductible 50% Plan 50% Member
METABOLIC FORMULAS		
Metabolic Formulas	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER									
MORBID OBESITY											
No copayments apply. Medically necessary panniculectomies not covered.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member									
NUTRITIONAL THERAPY											
Six (6) visit maximum per Benefit Period. Preferred not subject to deductible.	After Copayment 90% Plan 10% Member	After Deductible 70% Plan 30% Member									
ORAL SURGERY											
Oral Surgery (Accidental injury and/or Disease)	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member									
Bony impacted wisdom teeth. In office setting only. Coinsurance applies even after coinsurance maximum is met. Preferred not subject to deductible.	50% Plan 50% Member	Not Covered									
OUTPATIENT MEDICAL CARE (Physician Office/ Home visits)											
Covered Services are provided for an unlimited number of visits per person, per Benefit Period. Sick office visits with a Preferred Provider are excluded from deductible. <ul style="list-style-type: none"> • \$15.00 Copayment -- Primary Care Physician (PCP) • \$15.00 Copayment – Specialist Physician 	After Copayment 100% Plan 0% Member May be subject to Deductible	After Deductible 70% Plan 30% Member									
OXYGEN AND RELATED EQUIPMENT/ SUPPLIES											
Coverage is provided for unlimited oxygen and supplies for home use.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member									
PRESCRIPTION DRUGS											
<ul style="list-style-type: none"> • Retail Prescription: <ul style="list-style-type: none"> ○ (30-day supply) ○ Oral Contraceptives covered 	After Copayment 100% Plan 0% Member	No Coverage									
			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">RX TIER</th> <th style="width: 50%;">COPAY</th> </tr> <tr> <td>Tier 1:</td> <td>\$10.00</td> </tr> <tr> <td>Tier 2:</td> <td>\$20.00</td> </tr> <tr> <td>Tier 3:</td> <td>\$35.00</td> </tr> </table>	RX TIER	COPAY	Tier 1:	\$10.00	Tier 2:	\$20.00	Tier 3:	\$35.00
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Tier 2:	\$20.00										
Tier 3:	\$35.00										
Tier 1:	\$10.00										
Tier 2:	\$20.00										
<ul style="list-style-type: none"> • Mail Order Prescription: (<i>Maintenance Medications</i>) <ul style="list-style-type: none"> ○ (90-day supply) ○ Oral Contraceptives covered 	After Copayment 100% Plan 0% Member	No Coverage									
			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">RX TIER</th> <th style="width: 50%;">COPAY</th> </tr> <tr> <td>Tier 1:</td> <td>\$20.00</td> </tr> <tr> <td>Tier 2:</td> <td>\$40.00</td> </tr> <tr> <td>Tier 3:</td> <td>\$105.00</td> </tr> </table>	RX TIER	COPAY	Tier 1:	\$20.00	Tier 2:	\$40.00	Tier 3:	\$105.00
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Tier 3:	\$105.00										

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
PREVENTIVE CARE		
Covered Services performed by Professional Providers include		
<ul style="list-style-type: none"> • Allergy Extract/Injections 	After Deductible After Copayment 90% Plan 10% Member	After Deductible 70% Plan 30% Member
<ul style="list-style-type: none"> • Immunizations: Adult 	After Deductible After Copayment 90% Plan 10% Member	After Deductible 70% Plan 30% Member
<ul style="list-style-type: none"> • Immunizations: Pediatric and Childhood 	After Copayment 100% Plan 0% Member May be subject to Deductible	70% Plan 30% Member May be subject to Deductible
<ul style="list-style-type: none"> • Preventive Screenings: <ul style="list-style-type: none"> ○ Screening Mammograms (Age 40+) ○ Colorectal Cancer Screening (Age 50+) ○ Prostate Screening (PSA) (One Per Benefit Period) 	After Copayment 90% Plan 10% Member Not Subject to Deductible	70% Plan 30% Member Not Subject to Deductible
<ul style="list-style-type: none"> • Routine Adult Well Care 	After Deductible After Copayment 90% Plan 10% Member	After Deductible 70% Plan 30% Member
<ul style="list-style-type: none"> • Routine Gynecological Examination and Pap Smears 	After Copayment 90% Plan 10% Member Not Subject to Deductible	70% Plan 30% Member Not Subject to Deductible
<ul style="list-style-type: none"> • Routine Pediatric Well Care 	After Copayment 90% Plan 10% Member Not Subject to Deductible	70% Plan 30% Member Not Subject to Deductible
PRIVATE DUTY NURSING		
Private Duty Nursing	Not covered	Not covered

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
SECOND SURGICAL OPINION		
Second opinion consultations for Surgery to determine the Medical Necessity of an elective surgical procedure are covered.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
SKILLED NURSING FACILITY		
Inpatient Facility Services: Sixty (60) days Maximum per Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Failure to Pre-certify services in a Non-Preferred Facility Provider or Preferred Facility Provider outside First Priority Life Insurance Company Area will result in a reduction of Covered Services payable for these services.	N/A	\$500 Facility 50% Plan 50% Member
Inpatient Professional Services: Two (2) visits during first week of confinement and one (1) visit per week for each consecutive week of confinement thereafter. Each day of Skilled Nursing Facility Medical Care reduces the medical surgical Benefit Period by one (1) day.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
SUBSTANCE ABUSE AND DEPENDENCY		
INPATIENT SERVICES:		
Inpatient Hospital Detoxification: Seven (7) days per admission. • Lifetime Benefit Maximum of four (4) confinements.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Inpatient Non-Hospital Residential Care: Thirty (30) days per Benefit Period. • Lifetime Benefit Maximum of ninety (90) days.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Inpatient Professional Services: Thirty (30) visits Maximum per Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Failure to Pre-certify services in a Non-Preferred Facility Provider or Preferred Facility Provider outside First Priority Life Insurance Company will result in a reduction in Covered Services payable for Inpatient services.	N/A	\$500 Facility 50% Plan 50% Member
OUTPATIENT SERVICES :		
Outpatient Facility Services: Thirty (30) full sessions or equivalent partial visits per Benefit Period. Thirty (30) additional full sessions or equivalent partial visits may be exchanged on a two for one basis to obtain up to fifteen (15) additional days of Non-Hospital Residential Care. • Lifetime Benefit Maximum One Hundred Twenty (120) visits.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

COVERED SERVICE	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
SUBSTANCE ABUSE AND DEPENDENCY (CONT'D)		
Outpatient Professional Services: Thirty (30) visits Maximum for Outpatient visits per Benefit Period.	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
SURGERY		
In hospital outpatient department, short procedure unit or free standing surgical unit	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, payment will be the Provider's Reasonable Charge for the highest paying procedure and no allowance for additional procedures except where it is initially determined by First Priority Life Insurance Company that an additional allowance is warranted. Initial Pre-certification may be required for certain procedures.		
Pre-certification Penalty – Failure to initially obtain Pre-certification to a Non-Preferred Professional Provider or out of state services will result in a reduction in professional Covered Services payable for surgical service.	N/A	\$500 Facility 50% Plan 50% Member
THERAPY – OUTPATIENT		
Chemotherapy, Radiation Therapy, and Dialysis Treatment	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
Cardiac Rehabilitation Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, Respiratory Therapy, and Speech Therapy	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member
OUTPATIENT THERAPY LIMITATIONS: <ul style="list-style-type: none"> • Cardiac Rehabilitation Therapy is limited to thirty-six (36) visits per Benefit Period. • Outpatient Occupational Therapy, Physical Therapy, or Speech Therapy, are limited to a combined Maximum of thirty-six (36) sessions per Benefit Period. • Pulmonary Rehabilitation Therapy is limited to a Maximum of eighteen (18) sessions per Benefit Period. • Respiratory Therapy is limited to a Maximum of eighteen (18) sessions per Benefit Period. 		
TRANSPLANT SURGERY		
Transplant Surgery	After Deductible 90% Plan 10% Member	After Deductible 70% Plan 30% Member

SECTION VI: DESCRIPTION OF COVERED SERVICES

ADULT IMMUNIZATIONS

Covered Services are provided for immunizations, including the immunizing agents, which are initially determined to be Medically Necessary. Immunizations required solely for international travel are not covered. The Plan may cover adult immunizations for the purpose of work. Preauthorization required.

ALLERGY EXTRACT/ INJECTIONS

Covered Services are provided for allergy extract injections.

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:

- From home or from the scene of an accident or Medical Emergency, to the nearest Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to the Participant's home; or
- From home or from a Facility Provider to an Outpatient treatment site.

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 Provider's Reasonable Charge for transportation to the closest facility that can provide the necessary services.

BLOOD

Covered Services are provided for whole blood, blood plasma, administration of blood and blood processing, and blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

CHIROPRACTIC COVERED SERVICES

For Participants age thirteen (13) and above, Chiropractic Covered Services, including Spinal Manipulation and Adjunctive Procedures, are limited to a combined Maximum of eighteen (18) visits per Benefit Period, when provided by a doctor of Chiropractic who is a Participating Provider, if Medically Necessary. No coverage is provided for Covered Services under the age of thirteen (13).

DIABETES EDUCATION

Covered Services include participation in a Facility Provider's diabetes self management training and education program under the supervision of a Licensed health care professional with expertise in diabetes. Coverage for self management education and education relating to diet, prescribed by a Licensed Physician, includes: Visits Medically Necessary upon the diagnosis of diabetes;

- Visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitate change in a patient's self management and when a new medication or therapeutic process relating to the patient's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed physician.

Services will be covered only when provided by a Facility Provider subject to the criteria of BlueCross. These criteria are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association.

DIAGNOSTIC MAMMOGRAMS

Covered Services are provided for diagnostic mammograms whether or not directed toward a definite condition of disease or injury and ordered by a Physician. Diagnostic Mammograms are subject to Deductible and Coinsurance.

DURABLE MEDICAL EQUIPMENT, AND ORTHOSES AND PROSTHESES

Subject to any Maximum limits set forth in the Schedule of Covered Services, the following Covered Services are provided:

Durable Medical Equipment

The rental (but not to exceed the total allowance of purchase) or, at the option of BlueCross and Blue Shield and/ or the Plan, the purchase of Durable Medical Equipment when Prescribed by a Professional Provider and required for therapeutic use, when initially determined to be Medically Necessary by First Priority Life Insurance Company.

Orthoses and Protheses

Medical expenses for Orthoses and Protheses are subject to medical review by First Priority Life Insurance Company to initially determine eligibility and Medical Necessity.

Such expenses may include, but not be limited to, the following:

- The purchase, fitting, necessary adjustments and repairs of Protheses and supplies which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
- Orthopedic braces (excluding corrective shoe unless such shoes are attached to the braces) and Orthoses necessary for alleviation or correction of conditions due to injury, illness, or congenital deformities occurring on or after a Participant's Effective Date.
- Eyeglasses or contact lenses, limited to \$350, 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:
 - Contact lenses used for treatment of infantile glaucoma;
 - Corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
 - Scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 - Corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

Covered Services for replacement of a Protheses will be provided only for a dependent child due to normal growth process, when medically necessary.

Covered Services are not payable for dental appliances, wigs, or eyeglasses except as specified above.

Oxygen and Related Equipment Supplies

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

EMERGENCY CARE COVERED SERVICES

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. However, if the accident services are classified as Surgery (e.g. suturing, fracture care, etc.) payment to a Professional Provider will be made as a surgical covered service. Visits that are follow-up to Emergency Accident Care are classified and payable as Outpatient Medical Care.

HOME HEALTH CARE

Subject to any Maximum limits shown in the Schedule of Covered Services, Covered Services will be provided for the following when performed by a Licensed Home Health Care Agency:

- Professional services of a Registered Nurse or Licensed Practical Nurse, but not including Special Duty Nurses;
- Home Health Aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
- Physical Therapy treatments when provided by a Licensed Physical Therapist;
- Speech Therapy Services when provided by a Licensed Speech Therapist holding a certificate of clinical competency;
- Occupational Therapy treatments when provided by or supervised by a Licensed Occupational Therapist;
- Medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;
- Nutritional guidance counseling when provided by a registered dietician;
- Diagnostic and therapeutic radiology services;
- Laboratory services;
- Medical diagnostic tests and studies;
- Oxygen and respiratory therapy;
- Medical and surgical supplies including bandages, dressings and casts;
- 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.

Covered Services will be provided only for services if (a) the services are prescribed by the Participant's attending Physician, (b) the Participant's Physician has furnished, in consultation with the Home Health Care Agency's professional personnel prior to the first visit, a written 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.

No Home Health Care Covered Services will be provided for:

- Food or home delivered meals;
- Professional medical services billed by a physician;
- Custodial Care;
- Services of a housekeeper;
- Private duty nursing;
- Ambulance services;
- Drugs other than prescribed drugs; and such other non-legend drugs not specifically designated by BlueCross and Blue Shield;
- Services of immediate family or members of the Participant's household.

A visit occurs when the Participant receives treatment at home from one of the qualified professionals as listed under the Covered Services.

HOME INFUSION THERAPY

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

- Total parenteral nutrition;
- Enteral nutrition;
- Intravenous therapy;
- Chemotherapy;
- Anti-infective therapy;
- Pain management (continuous and epidural analgesics);
- Enzyme replacement;
- Immune globulin therapy.

The Home Infusion Therapy agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic Covered Services 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 (parenteral only).

Covered Services will be provided if: (a) the Home Infusion Therapy Agency has a Participating Provider agreement with BlueCross, (b) the services are prescribed by the Participant's Physician, and the Participant's Physician has furnished, in consultation with the Home Infusion Therapy agency's professional personnel, prior to the first visit, a written plan of treatment stating that the services ordered are Medically Necessary. Continuing eligibility requires that the prescribing Physician provide such a plan of treatment at intervals of no less than every thirty (30) days.

Home Infusion Therapy Covered Services will not be provided for:

- Participants who are receiving Covered Services under the Hospice Care program;
- Blood and blood products therapy;
- Infant formulas prescribed for reasons of lactose intolerance, milk protein intolerance, milk allergies, or metabolic disorders;
- Any injectable drugs covered under any other Covered Service section of this Benefit Schedule; and
- Oral supplements, which do not provide a minimum of fifty (50) percent of daily nutrition.

HOSPICE CARE

When the Participant's attending Physician certifies in writing to BlueCross and Blue Shield that the Participant has a terminal illness with a medical prognosis 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 Covered Services when provided in the home by a Hospice.

Respite Care on a short term Inpatient basis in a Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary care givers in the patient's home. Covered Services are payable according to the Maximums set forth in the Schedule of Covered Services.

Covered Services for Hospice care shall be provided for up to one hundred eighty (180) days. These Covered Services are in addition to, and not in lieu of, any other Covered Services. 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.

Covered Services will be provided for palliative and supportive services 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 Insurance Company. The following services provided to a homebound Participant by an approved Hospice Care Agency responsible for the patient's overall care will be eligible for coverage:

- Professional services of a Registered Nurse or Licensed Practical Nurse;
- Home Health Aide services;
- Laboratory services;
- Therapy Services except dialysis treatments;
- Medical and surgical supplies and durable medical equipment;
- Prescription Drugs;
- Oxygen and its administration;
- Medical social service consultations;
- Palliation for pain control and symptom management;
- Respite Care in Skilled Nursing Facility, limited to five (5) days in a three (3) month period;
- Family counseling services related to the Participant's terminal condition;
- Dietitian services;
- Hospice Inpatient room, board and general nursing services for acute pain management (payable under the Hospital Covered Services); and
- Bereavement counseling (limited to two (2) visits).

The Hospice Care program must deliver Hospice Care in accordance with a treatment plan approved by and periodically reviewed by First Priority Life Insurance Company.

No Hospice Care Covered Services will be provided for:

- Services and supplies for which there is no charge;
- Research studies directed to life lengthening methods of treatment;
- Medical Care rendered by the Participant's private physician;
- Pastoral services;
- Services or expenses incurred in regard to the patient's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions or personal real property); and
- Care provided by family members, relatives, or friends.

HOSPITAL SERVICES: 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:

- Meals, including special meals or dietary services as required by the patient's condition;
- Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- Oxygen and oxygen therapy;
- 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 in this section;
- Anesthesia and the supplies and use of anesthesia equipment;
- Diagnostic Services;
- Therapy Services;
- All FDA-approved drugs (including intravenous solutions, cancer Chemotherapy and cancer hormone treatment) for use while in the Hospital,
- Use of special care units, including but not limited to, Intensive or Coronary Care; and
- 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.
- Inpatient rehabilitation therapy limited to forty-five (45) days per Benefit Period and requires Prior Authorization

Covered Services for Pre-Admission Testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancel or postpones the admission, Covered Services will be provided.

HOSPITAL SERVICES: 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:

- An average Semi-private room, as designated by the Hospital; or a private room, when designated by First Priority Life Insurance Company as a Semi-private, in Hospitals having primarily private rooms;
- A private room. Private room allowance is the average Semi-private room charge;
- 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;
- A bed in a general ward;
- Nursery facilities;
- The length of stay following a Mastectomy that the treating Physician initially determines is necessary to meet generally accepted criteria for safe discharge.

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 count as one day.

Days available shall be allowed only during uninterrupted stays in a Hospital. Covered Services shall not be provided: (1) during the absence of a Participant who interrupts his stay and remains past midnight of the day on which the interruption occurred or (2) after the discharge hour that the Participant's attending Physician has recommended that further Inpatient care is not required.

MASTECTOMY AND BREAST RECONSTRUCTION

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

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
- Initial and subsequent Prosthetic devices to replace the removed breast or portions thereof; and
- Physical complications of all stages of Mastectomy, including lymphedemas.

Coverage is also provided for one Home Health Care visit, as initially determined by the Participant's Physician, received within forty-eight (48) hours after discharge.

MATERNITY SERVICES

Services rendered in the care and management of a pregnancy for a Participant are Covered Services under the Plan as specified in the Schedule of Covered Services. Covered Services are payable for:

Normal Pregnancy

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

Complication 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.

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 initially 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 initially determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum, and post partum 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 provided for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. 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 assessment. The post partum home health visit is exempt from any Deductible, Copayments, or Coinsurance.

Nursery Care

Ordinary nursery care of the newborn infant

MEDICAL CARE

Inpatient

Medical Care rendered by the Professional Provider in charge of the case to a Participant who is an Inpatient in a Hospital, Rehabilitation Hospital, or Skilled Nursing Facility for a condition not related to Surgery, Maternity Service, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Participant whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

- **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 required by a Facility Provider's rules and regulations.

- **Consultations**

Consultation services when rendered to an Inpatient in a 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 consultation during any Inpatient confinement.

Outpatient Medical Care

Medical care, visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient for a condition not related to surgery, pregnancy, or Mental Illness, except as specifically provided. Covered Services are provided for the examination, diagnosis, and treatment of an illness or injury and routine visits.

Outpatient Mastectomy

Outpatient care is provided following a Mastectomy performed in a health care facility.

Therapeutic Injections and Drugs Requiring Physician Administration

Covered Services are provided for FDA-approved therapeutic injections and drugs, including Chemotherapy, requiring physician administration required in the treatment of an illness or injury.

MENTAL HEALTH CARE SERVICES

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

Inpatient Treatment

Covered Services are provided, subject to the Benefit Period and Lifetime Maximums stated in the Schedule of Covered Services for an Inpatient admission for treatment of Mental Illness or Serious Mental Illness. Inpatient visits for the treatment of Mental Illness and Serious Mental Illness are covered when performed by a Professional Provider. Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

Partial Hospitalization

Covered Services for Partial Hospitalization Psychiatric Care Services are only available when provided by a Preferred Facility Provider. Such programs must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

Outpatient Treatment

Covered Services are provided, subject to the Benefit Period and Lifetime Maximums shown in the Schedule of Covered Services, for Outpatient treatment of Mental Illness and Serious Mental Illness.

Covered Services include treatments such as psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

Family counseling, counseling with family members to assist in the Participant's diagnosis and treatment, is covered when performed by a Professional Provider.

Covered Services are not payable for the following services:

- vocational or religious counseling;
- activities that are primarily of an educational nature;
- treatment modalities that have not been incorporated into the commonly accepted therapeutics repertoire as initially determined by broad based professional consensus such as but not limited to primal therapy, rolfing or structure integration, bioenergetics therapy, and obesity therapy;
- Facility Provider charges for family counseling service.

Covered Service Maximums for Psychiatric Care

Benefit Period:

All psychiatric services are covered up to any applicable Maximum amount per Benefit Period specified in the Schedule of Covered Services.

Lifetime Maximum:

All psychiatric services are covered up to the lifetime Covered Service Maximum specified in the Schedule of Covered Services. The Maximum is part of, not in addition to, the overall lifetime Covered Service Maximum.

METABOLIC FORMULAS

Covered Services will be provided only for the therapeutic treatment of phenylketonuria (PKU) branched chain ketonuria, galactosemia and homocystinuria. The 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.

NUTRITIONAL THERAPY

Nutritional Therapy is available to Insured Persons when provided by a Licensed Dietitian up to the Maximum of \$250 per Insured per Benefit Period. Diabetes Outpatient self-management training and education and Nutritional Therapy provided to a Homebound Insured under Home Health Care Section are exempt from this Benefit Maximum. Coverage for dependent children, who are insured under this Policy, 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).

OBSERVATION STATUS

In accordance with First Priority Health's policies and procedures, services of certain Participating Providers and all Non-Participating Providers require Prior Authorization. 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.

PEDIATRIC AND CHILDHOOD IMMUNIZATIONS

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as initially 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. Covered Services are exempt from Deductibles and Maximums.

PRESCRIPTION DRUG

Covered Services are available at 100% of the allowance at a Participating Pharmacy subject to a Co-payment. For a Preferred Tier 1 Generic or Generic Equivalent Prescription Drug there is a \$10 Co-payment. For a Preferred Tier 2 Prescription Drug there is a \$20 Co-payment. For a Tier 3 Non-Preferred Prescription Drug there is a \$35 Co-payment. Co-payments are payable directly to a Participating Pharmacy for each Prescription.

For Mail Order or Maintenance Prescription Drugs from a Participating Mail Order Pharmacy, Tier 1 Generic or Generic Equivalent Prescription Drug there is a \$20 Co-payment. For a Preferred Tier 2 Preferred Prescription Drug there is a \$40 Co-payment. For a Tier 3 Non-Preferred Prescription Drug there is a \$105 Co-payment.

Prescription Drugs are not covered when purchased at a Non-Preferred Pharmacy, retail or mail order. Covered Services include Prescription Drugs dispensed by a Licensed Pharmacy on or after the Participant's Effective Date.

Prior Authorization:

The process whereby the Prescriber and/or Participant is given prior approval by First Priority Life Insurance Company for certain Prescription drugs which have been designated by First Priority Life Insurance Company as requiring prior authorization.

Limitations:

- Covered Services for drugs/supplies include: (a) Prescription drugs which can be self-administered, including oral contraceptives (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription drugs and insulin, (d) lancets, (e) glucose test strips, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other drugs/supplies which may be specifically designated by BlueCross and (i) the covered pharmaceutical services necessary to make such drugs available, not including, however, any drug or group of drugs specifically excluded at the direction of the Employer.
- Reimbursement will not exceed that set for the Generic Equivalent Drug; the difference in cost between the Brand-Name Drug and Generic Equivalent Drug will be payable by the Participant in addition to their Copayment.
- 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 BlueCross and the Plan.
- 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 BlueCross and the Plan.
- Prescriptions are refillable for a period not in excess of 1(one) year from the date written and further subject to refill limitations as set forth in federal and/or state law or by the Prescriber.
- 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 75% 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 BlueCross 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 BlueCross and the Plan.
- Special circumstances – 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 electronic claims/eligibility systems or for urgent or emergency needs, the Participant may request reimbursement for purchased Prescriptions from BlueCross. 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 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.
- 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

initially 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. Should a Prescription Drug, which requires Prior Authorization, be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant that Prior Authorization is required for coverage of the Prescription Drug.

- No Covered Services will be provided for a Prescription Drug when the Participant elects not to obtain or fails to obtain Prior Authorization or the Participant seeks reimbursement for a Prescription Drug, which is subsequently initially determined not to be Medically Necessary

Special Exclusions:

No Prescription Drug Covered Services will be provided for:

- A. Any Prescription Drug or supply which is not Medically Necessary based on one or more of the following reasons:

- (1) The indication and/or use are of a cosmetic nature or to enhance physical appearance; to enhance athletic performance; or for weight loss.
- (2) Based on the Pharmacists' professional judgment, the Prescription should not be dispensed.
- (3) 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 reasons:

- (a) The use of the Prescription Drug or supply is contraindicated due to: over utilization, drug-drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, drug allergy, iatrogenic effect.
- (b) The use of the Prescription Drug or supply is subject by BlueCross and the Plan to utilization criteria.

- (4) Charges for any Prescription Drug or supply being used for the prevention of pregnancy including injectable contraceptives, except when used for an approved medical condition.

- B. Charges for any Prescription Drug or supply, unless authorized, which are:

- (1) Experimental or investigative.
- (2) Not approved for use by the Food and Drug Administration.
- (3) Not approved for the specific indication by the Food and Drug Administration.

- C. The following exclusions are specifically included as follows:

- (1) Drugs which do not require a Prescription;
- (2) Drugs which cannot be self-administered;
- (3) Medical supplies;
- (4) Devices and equipment,
- (5) Test agents and devices except those used for diabetes;
- (6) Smoking-cessation aids including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by BlueCross which are covered for one treatment period per lifetime;
- (7) Multiple vitamins, except those used for pregnancy and multiple vitamins with fluoride for the prevention of dental caries in children under the age of 16;
- (8) Injectable drugs used to treat infertility;
- (9) The additional charge for a brand-name drug for which there is a Generic Equivalent Drug available;

- (10) Drugs for impotence in excess of 4 doses per month;
- (11) Allergy extracts for allergen immunotherapy;
- (12) Drugs dispensed to a Participant as an Inpatient or Outpatient when the drugs are available under any health insurance program other than this drug program;
- (13) Drugs dispensed to a Participant while a patient in a Provider for which Covered Services are available under any health insurance program;
- (14) Replacement of lost, stolen or damaged drugs.

PREVENTIVE CARE SERVICES

Routine Pediatric Care

Pediatric care includes routine physical examinations, regardless of Medical Necessity. Covered Services are limited to Participants under 18 years of age in accordance with a pre-defined schedule.

Routine Adult Care

Adult care includes routine physical examinations, regardless of Medical Necessity, including a complete medical history plus necessary diagnostic services. Covered Services are limited to Participants 18 years of age and older in accordance with a pre-defined schedule.

Routine Gynecological Examinations and Pap Smears

Female Participants are covered for one (1) annual gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine pap smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Covered Services are exempt from Deductibles and Maximums.

Screening Mammograms

Covered Services are provided for one (1) screening mammogram per Benefit Period for females forty (40) years of age and older, and any mammogram for females under the age forty (40) when recommended by a Physician. Covered Services are exempt from Deductibles and Maximums. Covered Services for mammography screening are payable only if performed by a mammography service Provider who is properly certified by the Department of Health.

Colorectal Cancer Screening

Coverage is provided for fecal occult blood tests; a screening with barium enema once every five (5) years beginning at age fifty (50); flexible sigmoidoscopy, one (1) beginning at age fifty (50) every five (5) years; and a colonoscopy, every ten (10) years beginning at age fifty (50). Covered Services are exempt from all Deductibles or as indicated on the Outline of Coverage.

Prostate 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 or as indicated on the Outline of Coverage.

PRIVATE DUTY NURSING

Covered Services shall be provided up to the Maximum specified in the Schedule of Covered Services for Outpatient services for Private Duty Nursing services performed by a Licensed Registered Nurse (RN), or a Licensed Practical Nurse (LPN), when ordered by a Physician.

Covered Services are not payable for:

- Private Duty Nursing services provided for Inpatient care;
- Custodial Care;
- Services provided by a nurse who ordinarily resides in the Participant's home or is a member of the Participant's immediate family;
- Services provided by a Home Health Aide or a nurse's aide.

SKILLED NURSING FACILITY CARE

Covered Services are provided for care in a Skilled Nursing Facility, when initially determined to be Medically Necessary by First Priority Life Insurance Company, up to the Maximum limits specified in the Schedule of Covered Services. The Participant must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Facility.

The Participant's attending Physician must provide First Priority Life Insurance Company with a statement that skilled nursing care in a skilled facility is Medically Necessary.

No Covered Services are payable:

- 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;
- 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
- For the treatment of alcoholism, drug addiction, or Mental Illness.

SURGERY

Surgery Covered Services will be provided for services rendered by a Professional Provider and/or Facility Provider 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.

Also covered is 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. Covered surgical procedures shall include any voluntary surgical procedure for sterilization, regardless of their Medical Necessity.

Hospital Admission for Dental Procedures or Dental Surgery

Covered Services will be payable for a Hospital Admission in connection with dental procedures or dental surgery only when the Participant has an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure the patient's health. Dental procedures or dental surgery performed during such a confinement will only be covered for the services below.

Oral Surgery

Dental oral surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Service only for: (1) treatment of diseases or injuries of the jaw; (2) treatment of fractures or dislocations; and (3) Surgical removal of teeth and maxillary or mandibular intrabony cysts, 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.

Removal of Bony Impacted Wisdom Teeth

Coverage for oral Surgery for 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, as specified in Schedule of Benefits for Covered Medical Expenses. When Surgery cannot be safely or adequately performed on an Outpatient basis for children under the age of eighteen (18) and for adults with severe mental retardation as authorized by First Priority Life's Medical Director, such Surgery may occur in a Hospital or Ambulatory Surgical Facility.

Local anesthesia is covered. Also, when Surgery cannot be safely or adequately performed on an Outpatient basis for children under the age of eighteen (18) and for adults with severe mental retardation, anesthesia charges for such Insured Persons will be covered if authorized by First Priority Life's Medical Director.

Dental Services Related to Accidental Injury

Dental services rendered by a Professional Provider and/or a Facility Provider which are required as a result of accidental injury to the jaws, sound natural teeth, mouth, or face occurring on or after the participant's effective date. Injury as a result of chewing or biting shall not be considered an accidental injury.

Assistant At Surgery

Services for a Participant by an assistant surgeon who actively assists the operating surgeon in the performance of covered surgery. The condition of the Participant or the type of surgery must require the active assistance of an assistant surgeon as initially determined by First Priority Life Insurance Company. 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.

Anesthesia

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

Except for local anesthesia, anesthesia charges associated with the removal of partially or totally bony impacted wisdom teeth are not covered. However, when Surgery cannot be safely or adequately performed on an Outpatient basis for children under the age of eighteen (18) and for adults with severe mental retardation and when it is authorized by First Priority Life's Medical Director, anesthesia charges will be covered.

Second Surgical Opinion

Second opinion consultations for surgery to initially determine the Medical Necessity of an elective surgical procedure are covered. Elective surgery is that surgery which is not of an emergency or life threatening nature.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the surgery. One (1) additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances the Participant will be eligible for a Maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

Surgery for Mastectomy

Surgical procedure for Mastectomy, including devices and Reconstructive Surgery incident to any Mastectomy. Covered Services will be provided for Prosthetic Devices inserted during Reconstructive Surgery and Reconstructive Surgery is limited to surgical procedures performed within six years of the date of the Mastectomy.

Surgical Treatment of Morbid Obesity

Gastric bypass for the surgical treatment of Morbid Obesity, including Physician services, provided the Participant is at least eighteen (18) years of age. This Covered Service is limited to one (1) procedure per lifetime.

THERAPY SERVICES

Covered Services shall be provided, subject to the Maximums specified in the Schedule of Covered Services, 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.

- Radiation Therapy including the cost of the radioactive materials.
- Dialysis Treatments.
- Cardiac Rehabilitation Therapy.
- Physical Therapy.
- Occupational Therapy, when performed by a Professional Provider or when Prescribed by a Physician and performed by an Occupational Therapist.
- Speech Therapy.
- Respiratory Therapy, when performed by a Professional Provider or when Prescribed by a Physician and performed by a respiratory therapist.
- Pulmonary Rehabilitation Therapy.

TRANSPLANT SURGERY

If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

- When both the recipient and the donor are Participants, each is entitled to the Covered Services of the Plan.
- When only the recipient is a Participant, both 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 the Plan or any government program. Covered Services provided to the donor will be charged against the recipient's coverage under the Plan.
- 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 the Plan or any government program available to the recipient. No Covered Services will be provided to the non-participating transplant recipient.
- 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's Plan Limit.

TREATMENT OF ALCOHOL AND/OR DRUG ABUSE AND DEPENDENCY

Inpatient Detoxification

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

- Lodging and dietary services;
- Physician psychologist, nurse, certified addiction counselors and trained staff services;
- Diagnostic x-ray;
- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, equipment use and supplies.

Inpatient Non-Hospital Residential Care

Covered Services are provided for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility, subject to the Maximums shown in the Schedule of Covered Services. The following services will be covered when administered by an employee of the facility:

- Lodging and dietary;
- Physician, psychologist, nurse, certified addiction counselors and trained staff services;
- Rehabilitation Therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, equipment use and supplies.

Outpatient Facility Services for Treatment of Alcohol and/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:

- Physician, psychologist, nurse, certified addiction counselors and trained staff services;
- Rehabilitation Therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, equipment use and supplies.

SECTION VII: EXCLUSIONS

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.
2. Any services in connection with or required by a non-covered procedure or Covered Service, 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. Coverage will not be provided for services related to medical research.
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; actinic changes; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the visible portion of 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. Except as described Description of Covered Services Section and the Outline of Coverage:
 - Hospital and Ambulatory Surgical Facility services provided on an Inpatient or Outpatient basis in connection with the extraction of partially or totally bony impacted wisdom teeth; and • Anesthesia charges, other than local anesthesia, associated with the extraction of partially or totally bony impacted wisdom teeth. Except as described in Description of Covered Services Section and for dental services directly associated with baby bottle syndrome if prior to age four (4) and limited to one (1) treatment per life time:
 - All dental services including diagnostic, preventive and primary dental care, regardless where or by whom performed, related to the care, filling, removal or replacement of natural teeth, dentures or bridges and treatment of diseases of the teeth or gums, including, but not limited to: treatment of dental cavities, periodontics, endodontics, orthodontics, and orthognathic Surgery.
 - Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.
17. Services for which Covered Services are available under Medicare or other governmental program, except Medicaid, a state or federal workers' compensation, employer's liability or occupational disease law or services provided by a member of the covered person's Immediate Family.
18. 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.
19. Treatment of pervasive developmental disorders such as autism or mental retardation, defects, deficiencies and learning disabilities. This exclusion does not apply to medical treatment of such Participant in accordance with the Covered Services provided the Description of Covered Services.

20. Mental health care and/or Substance Abuse services rendered in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
21. Services for the treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders without a known physical basis or due to a general medical condition.
22. Mental health care services for the treatment of Mental or Nervous Disorders, which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, including, but not limited to: anti-social personality, conduct disorders and paraphilias.
23. Substance Abuse services utilizing methadone or methadone-like equivalents.
24. Biofeedback/neurofeedback.
25. 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.
26. Routine and cosmetic foot care, except for care provided as certified Medically Necessary for children due to the growth process or for care provided as a result of diabetes.
27. The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes.
28. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.
29. Custodial care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.
30. Physical, psychiatric or psychological examinations, testing, reports, vaccinations, immunizations 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.
31. Other than as specified for the treatment of Morbid Obesity in the Description of Covered Services, Surgery, 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.
32. Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except those providing 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. 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. 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 Insured claims the benefit compensation.

35. Long-Term Residential Care.

36. 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.

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

38. Pulmonary Rehabilitative Therapy on an Inpatient basis.

39. Reversal of voluntary sterilization.

40. Treatment in connection with transsexual Surgery, except for treatment resulting from a complication of such transsexual Surgery.

41. Charges in connection with penile implants.

42. 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.

43. 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.

44. 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.

45. 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.

46. 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.

47. 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.

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

49. Services for which a Participant would have no legal obligation to pay.

50. 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, menotropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.

51. Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise initially 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, ostomy supplies, or self-administered catheters or prosthetic socks, except when administered by a home health agency as part of the home health Covered Services; (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) dental services or appliances of any sort, including, but not limited to: dentures, bridges, dental implants, or intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in the Description of Covered Services, Durable Medical Equipment/Prostheses/Orthoses; (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.

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

53. Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in the Description of Covered Services, Ambulance Services.

54. Services performed by a Provider with the same legal residence as an Insured or who is a family member, including spouse, brother, sister, parent or child.

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

56. Adult circumcision in the absence of disease.

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

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

59. Educational classes, support groups and disease management programs unless sponsored or provided by First Priority Life or required for diabetes education services.

60. Unattended Services.

61. 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.

62. Charges to the extent payment has been made under Medicare or when Medicare is the primary carrier, or under another governmental program, except Medicaid.

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

SECTION VIII: PRESCRIPTION DRUG COVERAGE

A. DEFINITIONS

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.

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 also available upon request from BlueCare Service Representatives by calling toll-free 1-800-433-3746 weekdays during normal business hours or via First Priority Life's web site, www.bcnepa.com.

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.

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.

NON-PREFERRED PRESCRIPTION DRUG – Any Prescription Drug, which is not listed in the Drug Formulary by First Priority Life which are available at a Non-Preferred Prescription Drug Copayment. Non-Preferred Prescription Drugs are those listed in Tier 3.

PARTICIPATING COMMUNITY PHARMACY PROVIDER – Any Participating Pharmacy Provider, which is a public, walk-in Pharmacy.

PARTICIPATING MAIL ORDER PHARMACY PROVIDER – A Participating Pharmacy, which has entered into a Participating Mail Order Pharmacy agreement with First Priority Life.

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.

PARTICIPATING PHARMACY PROVIDER FOR SPECIALTY DRUGS – A Participating Pharmacy Provider, which has entered into a Specialty Drug Provider Agreement with First Priority Life.

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.

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.

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 1 or Tier 2 of the Drug Formulary.

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.

PRESCRIPTION – An order from a Prescriber for a single Prescription Drug of a particular strength and/or dosage form.

PRESCRIPTION DRUG – Any medication, which by federal and/or state law may not be dispensed without a Prescription order issued by a Prescriber.

PRESCRIPTION DRUG COPAYMENT – The amount a Participant must pay directly to Pharmacy Providers in connection with Covered Pharmacy Expenses as set forth in the Summary Plan Description.

PRESCRIPTION DRUG DEDUCTIBLE – A specified amount of Covered Pharmacy Expenses, usually expressed in dollars as set forth in the Summary Plan Description 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.

PRESCRIPTION DRUG MAXIMUM – The greatest Covered Service amount payable by First Priority Life for Covered Pharmacy Expenses as set forth in the Summary Plan Description.

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.

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 amounts specified in the Summary Plan Description 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.

There is a Coinsurance or Copayment specific to Prescription Drugs applicable for Plans with a single or multi-tier Prescription Drug coverage. The Prescription Drug Coinsurance or Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in the Summary Plan Description. This Prescription Drug Coinsurance or Copayment is not subject to any Coinsurance Maximum limitation for Covered Medical Expenses set forth in the Schedule of Covered Services for Covered Medical Expenses. Or There is a Prescription Drug Deductible per individual per Benefit Period as outlined in the Summary Plan Description for self-administrable Prescription Drugs and supplies. Once the Prescription Drug Deductible is satisfied, there is a Copayment specific to Prescription 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 Summary Plan Description. The Prescription Drug Copayment is not subject to any Coinsurance Maximum limitation for Covered Medical Expenses set forth in the Schedule of Covered Services for Covered Medical Expenses.

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, as specified in the Summary Plan Description, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, (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.

3. (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.

4. 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.

5. 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.

6. 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.

7. Special Circumstances - 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 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.

8. 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 must 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.

D. PRESCRIPTION DRUG EXCLUSIONS

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:

- a) The indication and/or use is of a cosmetic nature or to enhance physical appearance; to enhance athletic performance; or for weight loss.
- b) Based on the Pharmacist's professional judgment, the Prescription should not be dispensed.
- c) 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:
 - (i.) The use of the Prescription Drug or supply is contraindicated due to: over utilization, drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, or drug allergy.
 - (ii.) The use of the Prescription Drug or supply is subject by First Priority Life to utilization review criteria.

As outlined in the Summary Plan Description, if oral contraceptives are not covered, coverage will not be provided for any Prescription Drug or supply being used for the prevention of pregnancy, including all dosage forms of contraceptives, except when used for an approved medical condition. 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.

Unless specifically included in the 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.
- (14) tier zero drugs

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits group health plans and health insurance issuers from restricting the length of a hospital stay in connection with childbirth, the plan or health insurance issuer does not have to cover the full 48 or 96 hours in all cases. If an attending Provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, the group health plan and health insurance issuers do not have to continue covering the stay for whichever one of you is ready for discharge. An attending Provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending Provider. A plan, hospital, insurance company, or HMO would NOT be an attending Provider.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

IMPORTANT NOTICE TO HEALTH PLAN PARTICIPANTS AND COVERED FAMILY MEMBERS

The federal *Women's Health and Cancer Rights Act*, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a mastectomy. The new federal law requires group health plans that provide mastectomy coverage to also cover breast reconstruction surgery and prosthesis following mastectomy.

As required by law, you are being sent this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary mastectomy will also receive coverage for:

- ❖ **reconstruction of the breast on which the mastectomy has been performed;**
- ❖ **surgery and reconstruction of the unaffected breast to provide a symmetrical appearance; and**
- ❖ **coverage for prosthesis and treatment of physical complications of all stages of treatment for mastectomy, including lymphedemas.**

This coverage will be subject to the same annual deductibles and coinsurance provisions that currently apply to mastectomy coverage, and will be provided in consultation with you and your attending physician.