

Company Name:	Northern Tier Insurance Consortium (NTIC) Southern Tioga School District Option E	Group Number(s):	055541000, 055684000
Company Code:	200210	Dependent/Student Age Limit:	19/23 end of year
Effective Date:	7/1/2010	New Born Children:	31 days
Renewal Date:	7/1/2011	Full-time student leave of absence:	Covered
Date - Part II Benefit Schedule:	7/1/2010	Domestic Partners:	Not Covered
Outline of Coverage Revision Date:	7/1/2010	Credit (initial benefit period only)	n/a
		Claims Appeal Fiduciary	BCNEPA
		Benefit Period	Calendar Year

Participant Responsibility				Benefit Change Date/ Non-Standard Change Date
	Preferred*	Non-Preferred**	Limitations/ Non-Standard	
Deductible per person	\$250	\$500	Per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Deductible per family	\$750	\$1,500	Maximum 3 separate deductibles per family, per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance	0%	20%	Allowable Charge ¹	
Coinsurance maximum per person	None	\$3,000	Per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance maximum per family	None	\$9,000	Maximum 3 separate coinsurance maximums per family, per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Lifetime Maximum	Unlimited	\$1,000,000		
Primary Care Office Visits	\$20	20%	Unlimited Visits. Preferred coverage not subject to deductible.	
Specialty Care Office Visits	\$40	20%	Unlimited Visits. Preferred coverage not subject to deductible.	
Newborn Children	0%	20%	Newborn child claims are not subject to the deductibles	
Precertification Penalty (facility)	None	\$500		

Preventive Care Services

Participant Responsibility				
	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Childhood Immunizations	0%	20%	Copay applies if office visit. Coinsurance applies if no office visit. Pediatric Preferred/Non-Preferred not subject to deductible.	
Routine gynecological exam and Pap Smears	\$40	20%	Preferred/Non-Preferred not subject to deductible. One routine exam per benefit period.	
Routine Physical Exams	\$20	20%	Preferred not subject to deductible.	
Mammography screenings/ diagnostic	0%	20%	Preferred/Non-Preferred not subject to deductible.	
Routine colorectal cancer and prostate cancer screening	0%	20%	Preferred/Non-Preferred not subject to deductible.	
Emergency Services				
Ambulance Emergency Transport	0%	0%	Preferred/Non-Preferred Emergency Transports only are not subject to deductible. Non-preferred participant maybe liable for charges that exceed the allowable charge.	
Ambulance - Non-Emergency Transport	0%	20%	Non-preferred participant maybe liable for charges that exceed the allowable charge.	
Emergency room visit	\$50	\$50	Preferred/ Non-Preferred not subject to deductible or coinsurance, copay waived if admitted to hospital.	
Inpatient Services				
Inpatient Copay per admission	Not Applicable	Not Applicable	Copay applies to inpatient: hospital, maternity, SNF, mental nervous, and detox.	
Inpatient hospital services	0%	20%	unlimited days per benefit period.	
Inpatient Rehabilitation	0%	20%	45 days per benefit period.	
Skilled nursing care	0%	20%	60 days per benefit period.	
Transplants	0%	20%		
Outpatient Services				
High-tech imaging (MRI, MRA, CT, PET Scans, nuclear cardiology)	\$75 copay per test	20%		
Diagnostic testing (lab tests, x-ray, etc.)	0%	20%		
Maternity care (outpatient Physician visits)	\$40	20%	neonatal circumcision is covered. Copay for initial office visit.	
Radiation, dialysis or chemotherapy	0%	20%		
Physical Therapy	\$40	20%	20 visits per Benefit Period.	
Speech Therapy	\$40	20%	12 visits per benefit period.	
Occupational Therapy	\$40	20%	12 visits per benefit period.	
Pulmonary Rehabilitation Therapy	0%	20%	18 visits per benefit period.	
Cardiac Rehabilitation	0%	20%	36 visits per benefit period.	
Respiratory therapy	0%	20%	18 visits per benefit period.	
Surgery	0%	20%		
Other Services				

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Autism Spectrum Disorders	0%	20%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21. Coverage is subject to any applicable copays, coinsurance, and/or deductible. \$36,000 limit per member per benefit period.	
Chiropractic manipulative benefits	\$40	20%	12 treatments per benefit period, ages 13 and up. All services billed by a chiropractor are applied to the chiropractic benefit. If no Coinsurance Specialty Copay applies per provider per visit.	
Durable medical equipment, Prosthetics, & Orthotics	0%	20%	\$5,000 maximum per benefit period combined durable medical equipment, prosthetics, and orthotics. Diabetic items are excluded from this dollar maximum.	
Ostomy Supplies	50%	Not Covered	Outpatient professional charges are eligible for certain ostomy supplies, tracheostomy and urinary catheters up to \$1,000 maximum per participant per benefit period. Amounts are applied to coinsurance maximum but will always pay at coinsurance amount.	7/1/2010
Home health services	\$40	20%	Specialty Copay applies per day per provider.	
Home Infusion (nurse visit)	\$40	20%	Specialty Copay applies to nurses visit only.	
Hospice care	0%	20%	180-day lifetime maximum.	
Private Duty Nursing	Not covered	Not covered		
Oral Surgery	0%	20%	General anesthesia related to non-covered dental procedures or non-covered oral surgery when approved by a medical director for children under the age of 18, adults with significant cognitive impairment or those with complex medical conditions is covered.	
Morbid Obesity	0%	20%	Copays apply if no Coinsurance: \$2,000 copay per procedure for medically necessary Gastric Bypass Procedures. \$1,000 copay per procedure for medically necessary panniculectomies.	
Nutritional Therapy	\$10	20%	6 visits per member per benefit period. Preferred not subject to deductible.	

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Bony impacted wisdom teeth	50%	Not covered	In office setting only. Coinsurance applies even after coinsurance maximum is met. Preferred not subject to deductible.	
Prescription Glasses/Contacts Following Cataract Surgery	0%	20%	Post-cataract prescription glasses or contact lenses are covered, limited to a lifetime maximum of \$350 per member.	
Infertility	0%	20%	Diagnostic services leading up to the diagnosis of infertility. Applicable copayment for office visits.	
Invitro Fertilization	Not covered	Not covered		
Artificial Insemination	0%	20%	3 attempts per lifetime	
Non-elective abortion	0%	20%		
Voluntary Sterilization	0%	20%	Reversals not covered.	
Prescription Drugs				
Deductible per person	None	Not Covered	4th quarter deductible carryover does not apply.	
Deductible per family	None	Not Covered		
Maximum per person	None	Not Covered	Excludes ancillary.	
Maximum per family	None	Not Covered	Per benefit period.	
Yearly maximum	None	Not Covered		
Lifetime maximum	None	Not Covered		
Formulary	Multi-tier	Not Covered		
Retail	Covered	Not Covered	30-day supply.	
Tier 0	\$0	Not Covered		
Tier 1	\$10	Not Covered		
Tier 2	\$20	Not Covered		
Tier 3	\$35	Not Covered		
Specialty Drugs (Tier 5)	Not Covered	Not Covered	10% Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of \$3,000 per participant per Benefit Period.	
Mail order	Covered	Not Covered	Up to a 90-day supply.	
Tier 0	\$0	Not Covered		
Tier 1	\$20	Not Covered		
Tier 2	\$40	Not Covered		
Tier 3	\$105	Not Covered		
Oral contraceptives	Covered	Not Covered		
Exclusive Home Delivery	No	Not Covered	One original fill plus one refill available at the retail pharmacy.	

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Select Home Delivery	Yes	Not Covered	Participants are required to make a choice about their maintenance prescription drugs. Participants will have 2 fills at the retail pharmacy and then be required to contact Express Scripts with a decision on their third fill to continue through the retail pharmacy or switch to a mail order program.	
Mandatory generic prescription drugs	Yes	Not Covered		
Quantity limits	Yes	Not Covered	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Yes	Not Covered	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Metabolic Supplement	Yes	Not Covered	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Yes	Not Covered	The program requires the use of a first step drug(s) before use of a 2nd or 3rd step drug.	
Prior Authorization	Yes	Not Covered	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Flu/Pneumonia/H1N1 Vaccine Program	Yes	Not Covered	Flu vaccines are provided and administered by pharmacists contracted to administer vaccines.	
Weight loss drugs	Not Covered	Not Covered		
Other				
Mental Health				
Inpatient services	0%	20%	Unlimited days	7/1/2010
Outpatient services	0%	20%	Unlimited visits.	7/1/2010
Substance Abuse				
Outpatient services	0%	20%	Unlimited visits.	7/1/2010
Detoxification	0%	20%	Unlimited visits.	7/1/2010
Inpatient Non-hospital residential services	0%	20%	Unlimited visits.	7/1/2010
Mental Health/Substance Abuse Ambulance				
Ambulance emergency	0%	0%	Not subject to deductible Non-preferred participant maybe liable for charges that exceed the allowable charge.	

Participant Responsibility				
	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Ambulance non-emergency	0%	20%	Non-preferred participant maybe liable for charges that exceed the allowable charge.	
Mental Health/Substance Abuse Emergency Room				
Emergency room visit	\$50	\$50	Preferred/ Non-Preferred not subject to deductible or coinsurance, copay waived if admitted to hospital.	
Exclusions	Please see attached			

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

¹ The allowable charge is established by a provider agreement or is the billed amount, whichever is less, and will be accepted by the preferred provider as payment in full for covered services less any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums. For a non-preferred provider, the allowable charge is the same amount First Priority Life would pay to a preferred provider. The Participant is liable for charges that exceed the allowable charge in addition to any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums.

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

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

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

PPO
Standard Exclusions

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

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

- A. Except as may be specifically provided in the Description of Covered Services, the following are not covered under the Plan:
1. Services which are not Medically Necessary, except those that are provided within the Policy for preventive services or those mandated by law.
 2. Any service in connection with or required by a procedure not set forth in the foregoing Description of Covered Services Section, except as necessitated by subsequent complications.
 3. Services in excess of any Benefit Maximum as stated.
 4. Charges for services or supplies incurred prior to the Participant's Effective Date.
 5. Except as provided by the Plan, charges for services or supplies incurred after the date of termination of the Participant's coverage.
 6. Charges, which exceed the Allowable Charge.
 7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.
 8. Services which First Priority Life initially determines are Experimental or Investigative; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative. 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; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following a Mastectomy; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.
 15. Treatment of temporomandibular joint (TMJ) or myofascial (MPD) pain dysfunction or craniomandibular (CMD) pain syndrome, including surgical and non surgical exam, invasive and non invasive procedures and tests, and all related medical and surgical services. Examples of non-Covered Services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.

16. With respect to the extraction of partially or totally bony impacted wisdom teeth:
 - Hospital and Ambulatory Surgical Facility services are not covered, except if authorized by a Medical Director of First Priority Life as set forth in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 3.
 - General anesthesia charges are not covered, except as indicated in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 3With respect to all other dental procedures and oral Surgery, the following are excluded:
 - Removal of natural teeth, except when removal of teeth is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations.
 - All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injuries to the jaws, natural teeth, mouth or face. Chewing or biting shall not be considered an accidental injury.
 - Dental appliances, including, but not limited to dentures and bridges, except for the primary restoration following facial/dental trauma or when an integral part of a cleft palate repair.
 - Periodontics, endodontics, and orthognathic Surgery.
 - Dental implants
 - Treatment of diseases of the teeth or gums, including, but not limited to treatment of dental cavities.
 - Periodontics, endodontics, and orthognathic Surgery.
 - Orthodontics, except orthodontic treatment related to cleft palate repair as described in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 1.
 - Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.
 - Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures unless such procedures were for the treatment of accidental bodily injury.
17. 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. · Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD under the Agreement and for Participants age twenty-one (21) and over.
 - Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in Section DB – Description of Covered Services.
 - Treatment of Autism Spectrum Disorder through the use of Chelation Therapy.
 - Any services listed in an Individual Education Plan (IEP) are not covered.
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 a result of diabetes.
27. The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes or as certified Medically Necessary for children due to the growth process.
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. 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. Transsexual Surgery and treatment and services in support of transsexual Surgery, except for treatment resulting from a complication of such transsexual Surgery.
40. Charges in connection with penile implants.
41. Abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.
42. Separate charges by interns, residents, and other health care professionals who do not have a Provider Agreement with First Priority Life, who are directly, or indirectly employed by a Hospital or Facility Other Provider which makes their services available.
43. Corneal Surgery to change the shape of the cornea to correct vision problems, except for accidental injury or Medically Necessary conditions resulting from corneal Surgery.
44. Routine eye examinations; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.
45. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to allergen filtration systems, including allergy products.
46. Charges for telephone calls or telephone consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.
47. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.
48. Assisted fertilization techniques such as, but not limited to, In Vitro Fertilization (IVF), of any kind including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment, embryo acquisition, storage and transport, human chorionotropin, urofollitropin, menotropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.

49. Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise determined by First Priority Life to be non-standard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, or prosthetic socks, except when administered by a home health agency as part of the home health benefit or as provided in Section DB – Description of Covered Services, Subsection X, Diabetes Education/Equipment/Supplies or Subsection FF, Ostomy Supplies; (d) exercise equipment; (e) self-help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or price of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in Section DB – Description of Covered Services, Subsection EE, 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.
50. Examinations for the prescription, fitting or adjustment of hearing aids.
51. Services performed by a Provider with the same legal residence as a Participant or who is a family member, including but not limited to: spouse, brother, sister, parent or child.
52. Alternative and complementary medicine, except as provided in the Care Coordination, Case Management.
53. Adult circumcision in the absence of disease.
54. Charges for a private room when a Semi-Private Room is available.
55. Services, which are not prescribed, performed or directed by a Provider licensed to do so.
56. Educational classes, support groups and disease management programs unless sponsored or provided by First Priority Life or required for diabetes education services.
57. Unattended Services.
58. Take-home drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider; injectable or implantable contraceptive drugs and devices that are not self-administrable (except when used for an approved medical condition other than contraception) and fertility drugs regardless of use; drugs in certain drug classes specifically designated by First Priority Life as Specialty Drugs including, but not limited to: self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives unless provided in connection with covered transplants, monoclonal antibodies, and other biotech drugs; except those drugs administered by a Preferred Professional Provider that are not self-administrable and/or that are provided incident to a Covered Service; those drugs that are mandated to be covered by law; and/or which are covered under the Prescription Drug Coverage, when coverage is provided for Prescription Drugs.

(The Outline of Coverage specifies whether Prescription Drug coverage applies.)