

***First Priority Life Insurance Company, Inc.
d/b/a First Priority Life***

*19 North Main Street
Wilkes-Barre, PA 18711*

BlueCare PPO Comprehensive Major Medical

Refer to the **Part I Outline of Coverage** for Covered Service, copayments, coinsurances, limitations and allowances specific to the Plan.

BLUECARE PREFERRED PROVIDER ORGANIZATION PROGRAM

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

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

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

SECTION DE - DEFINITIONS

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

- 1. ADJUNCTIVE PROCEDURES** – Physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization performed by an individual holding the appropriate licensure and certification.
- 2. ALCOHOL AND/OR DRUG ABUSE** – Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of the agreement, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).
- 3. ALLOWABLE CHARGE** – 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. With the exception of Emergency Care, the Participant may be liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Professional Provider, the Allowable Charge is based on the payment/rate that the Host Blue passes on to First Priority Life, or the billed amount, whichever less. With the exception of Emergency Care¹, the Participant will be liable for any Non-Preferred Participating Professional Provider Deductibles or Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred 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. With the exception of Emergency Care¹, the Participant is liable for charges that exceed the Allowable Charge in addition to any Non-

¹ In the event that the Participant received Emergency Care services by a Non-Preferred Participating/Non-Preferred Provider, First Priority will provide coverage at the Preferred Provider level and the Participant's out-of-pocket expenses will be no greater than the amount that would have been incurred if a Preferred Provider had been used.

Preferred Professional Provider Deductibles or Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

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

In the case of a Non-Preferred Participating Facility Provider, the Allowable Charge is the payment/rate that the Host Blue passes on to First Priority Life or the billed amount, whichever less. With the exception of Emergency Care¹, the Participant is liable for any Non-Preferred Participating Facility Provider Deductibles or Coinsurance, Copayments, amounts exceeding any Benefit Maximum, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Facility Provider, the Allowable Charge is the same amount First Priority Life would pay for services received by a Preferred Facility Provider, or the billed amount, whichever less. With the exception of Emergency Care¹, the Participant is liable for charges that exceed the Allowable Charge in addition to any Non-Preferred Facility Provider Deductibles or Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

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

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

4. **ALTERNATIVE TREATMENT PLAN** – A voluntary program whereby the Participant is offered cost-effective treatment alternatives in lieu of the stated Covered Services in the Agreement, without compromising the quality of care. First Priority Life’s Care Management Department, in cooperation with the Physician, organizes and coordinates care through multi-disciplinary resources.
5. **AMBULATORY SURGICAL FACILITY** – A Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, by the Accreditation Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to First Priority Life which:
 - a. has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
 - b. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the facility;
 - c. does not provide Inpatient accommodations; and
 4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

6. **APPLIED BEHAVIORAL ANALYSIS** – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
7. **AUTISM SERVICE PROVIDER** – A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in Pennsylvania. Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth's medical assistance program on or before the effective date of this section.
8. **AUTISM SPECTRUM DISORDER (ASD)** – Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.
9. **BEHAVIOR SPECIALIST** – An individual who designs, implements or evaluates a behavior modification intervention component of a Treatment Plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.
10. **BENEFIT PERIOD** – A Calendar Year or a Benefit Year. *(Refer to the Outline of Coverage for the period selected by the Plan.)*
11. **BENEFIT YEAR** – A period of twelve (12) consecutive months beginning with the Effective Date of the Plan during which charges for Covered Services must be incurred in order to be eligible for payment by First Priority Life. A charge shall be considered incurred on the date the service or supply was provided to a Participant. *(Refer to the Outline of Coverage for the period selected by the Plan.)*
12. **BEHAVIORAL HEALTH ACUTE CARE** – Health care delivered to a Participant, experiencing an acute illness or trauma, consisting of high level skilled psychiatric or Substance Abuse services within a free-standing psychiatric hospital, a psychiatric unit of a general hospital or a detoxification unit within a Hospital setting.
13. **BUSINESS DAY** – A day that First Priority Life is open for business.
14. **CALENDAR YEAR** – A one-year period which begins on January 1 and ends on December 31. *(Refer to the Outline of Coverage for the period selected by the Plan.)*
15. **CHEMOTHERAPY** – The treatment of disease by chemical or biological therapeutic agents.
16. **CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)** – A form of manual treatment to influence joint and neurophysiological function or the use of Adjunctive Procedures in treating misaligned and displaced vertebrae or articulation and related conditions of the nervous system provided by an individual holding the appropriate licensure and/or certification.
17. **COINSURANCE** – A specific percentage amount of the Allowable Charge, set forth in *the Outline of Coverage*, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.
18. **COINSURANCE MAXIMUM** – A specified dollar amount of Coinsurance incurred by a Participant, as set forth in *the Outline of Coverage*, for Covered Services in a Benefit Period. *(Refer to the Outline of Coverage for the period selected by the Agreement.)* The Coinsurance Maximum does not include removal of bony impacted wisdom teeth when performed by a Preferred Provider, penalties for failure to obtain Pre-Certification, Deductibles, Copayments, amounts in excess of the Allowable Charge, charges for non-Covered Services and charges after Covered Services have been exhausted, and any Deductible or Copayment amounts payable by the Insured for Covered Services under any rider attached to the Agreement.

- 19. COMMUNITY BEHAVIORAL HEALTHCARE NETWORK OF PENNSYLVANIA (CBHNP)** – First Priority Life’s dedicated unit that provides eligibility verification, triage, referral and utilization management for mental health-chemical recovery (behavioral health) services.
- 20. COPAYMENT** – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth in the Agreement and in ***the Outline of Coverage***.
- 21. COSMETIC PROCEDURE** – A medical or surgical procedure which is primarily performed to improve the appearance of any portion of the body.
- 22. COVERED SERVICES** – All Medically Necessary Provider services and supplies which are administered by First Priority Life under the terms of this Agreement.
- 23. CUSTODIAL CARE** – Services to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of skilled, trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential, or place of service.
- 24. DEDUCTIBLE** – A specified amount of Covered Services, as set forth in ***the Outline of Coverage***, expressed in dollars that must be incurred by a Participant before First Priority Life will assume any liability for all or part of the remaining Covered Medical Expenses.
- 25. DEPENDENT** – The spouse of a Participant; or the Participant’s or the Participant’s spouse’s unmarried child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.
- 26. DETOXIFICATION** – The process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol, drug or other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.
- 27. DIAGNOSTIC ASSESSMENT OF ASD** – Medically necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician Assistant, licensed Psychologist or Certified Registered Nurse Practitioner to diagnose whether an individual has an Autism Spectrum Disorder.
- 28. DIAGNOSTIC SERVICES** – The following procedures ordered by a Physician because of specific symptoms and signs to determine a definite condition or disease. Diagnostic Services are covered to the extent specified in Description of Covered Services and include, but are not limited to:
- a. diagnostic imaging;
 - b. diagnostic pathology, consisting of laboratory and pathology tests;
 - c. diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life; and
 - d. allergy testing consisting of percutaneous, intracutaneous and patch tests.
- 29. DURABLE MEDICAL EQUIPMENT** – Equipment which:
- a. can withstand repeated use; and

- b. is primarily and customarily used to serve a medical purpose; and
- c. generally is not useful to a person in the absence of an illness or injury; and
- d. is appropriate for use in the home.

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

31. EMERGENCY CARE – The treatment of a medical condition with sever or severe pain or sudden onset 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.

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

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

- a. Not accepted by the general medical community as standard medical treatment of the condition being treated or does not have definitive outcome studies in peer-reviewed medical literature demonstrating safety and efficacy for treating or diagnosing the condition or illness for which its use is proposed and/or lacks studies comparing outcomes to existing approved modalities of therapy or diagnosis; or
- b. Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information for the Health Care Professional as appropriate for the proposed use at the time services were rendered; or
- c. Subject to review and approval by any institutional review board for the proposed use; or
- d. The subject of an ongoing clinical trial that meets the definition of a phase I or II clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

36. FAMILY COVERAGE – Coverage for the Participant and one or more of the Participant’s Dependents.

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

- 38. FREESTANDING DIALYSIS FACILITY** – A Facility Other Provider, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home-care basis.
- 39. FREESTANDING OUTPATIENT FACILITY** – A Facility Other Provider, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.
- 40. 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 full-time in a trade or secondary school.
- 41. HIPAA** – The federal Health Insurance Portability and Accountability Act of 1996.
- 42. HOMEBOUND** – A Participant will be considered homebound if he/she has a condition due to an illness or injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated. The condition of these Participants should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.
- 43. HOME HEALTH CARE AGENCY** – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license:
- a. provides skilled Outpatient services on a visiting basis in the Participant's home; and
 - b. is responsible for supervising the delivery of such services under a plan authorized by the Physician
- 44. 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.
- 45. HOME INFUSION THERAPY AGENCY** – A Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life; is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license; provides Home Infusion Therapy services in the Participant's home or an infusion center; and is responsible for supervising the delivery of such services under a plan authorized by the Physician.
- 46. HOSPICE** – A Facility Other Provider, which is primarily engaged in providing supportive care to terminally ill individuals.
- 47. HOSPICE CARE** – A health care program which provides an integrated set of services, primarily in the patient's home, designed to provide supportive care intended to promote comfort to terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the Participant's Physician.
- 48. HOSPITAL** – A Provider that is a short-term, acute care or Rehabilitation Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Hospital Association, the Pennsylvania Department of Health, or a similar accrediting agency acceptable to First Priority Life, or a Provider that is a state-owned Psychiatric Hospital, and which:
- a. is a duly licensed institution;
 - b. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
 - c. has organized departments of medicine and/or major Surgery;

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

e. is not, other than incidentally, a:

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

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

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

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

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

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

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

55. 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.

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

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

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

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

- 60. MAXIMUM** – The greatest Covered Service amount payable by First Priority Life. This could be expressed in dollars, number of days, or number of services for a specified period of time.
- a. **BENEFIT MAXIMUM**– The greatest Covered Service amount payable by First Priority Life for a specific Covered Service.
 - b. **LIFETIME BENEFIT MAXIMUM** – The greatest Covered Service amount payable by First Priority Life in the Participant’s lifetime set forth in *the Outline of Coverage*.
- 61. MEDICAL CARE/MEDICAL SERVICES** – Services rendered by a Professional Provider intended to prevent illness (routine preventive care) and/or restore health (treatment of an illness or injury).
- 62. MEDICAL EMERGENCY** – A medical condition with severe pain or sudden onset 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.
- 63. MEDICALLY NECESSARY or MEDICAL NECESSITY** – Services or supplies rendered by a Provider that First Priority Life determines are:
- a. appropriate for the symptoms and diagnosis or treatment of the Participant’s condition, illness, disease or injury;
 - b. provided for the diagnosis, or the direct care and treatment of the Participant’s condition, illness, disease or injury;
 - c. in accordance with current standards of medical practice;
 - d. not primarily for the convenience of the Participant, or the Participant’s Provider; and
 - e. the most appropriate source or level of service that can safely be provided to the Participant. When applied to hospitalization, this further means that the Participant requires acute care as an Inpatient due to the nature of the services rendered or the Participant’s condition, and the Participant cannot receive safe or adequate care as an Outpatient.
- 64. MEDICARE** – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- 65. MENTAL OR NERVOUS DISORDER** – Mental, nervous, or emotional disorder means a neurosis, psychoneurosis, psychopathy, or psychosis.
- 66. METABOLIC FORMULAS** – Special nutritional formulas administered under the direction of a Physician, which are necessary to sustain life for a genetic metabolic disorder.
- 67. MORBID OBESITY** – The term refers to patients who have a body mass index (BMI) of 40 or greater.
- 68. NUTRITIONAL THERAPY** – Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a Licensed Dietitian to help a person make and maintain healthy dietary changes.
- 69. ORTHOSIS** – A rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

- 70. OSTOMY** – An artificial stoma or opening into the urinary tract, gastrointestinal canal or the trachea.
- 71. OSTOMY SUPPLIES** – Generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advise of a healthcare Provider.
- 72. OUTPATIENT** – A Participant who receives services or supplies while not an Inpatient.
- 73. PARTIAL HOSPITALIZATION PSYCHIATRIC CARE SERVICES** – The provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.
- 74. PARTIAL HOSPITALIZATION SUBSTANCE ABUSE SERVICES** – The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-hospital facility licensed by the Department of Health or provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient care.
- 75. PHARMACY CARE** – Medications prescribed by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner to determine the need or effectiveness of such medications.
- 76. PHYSICIAN** – A person, who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and prescribe and administer drugs.
- 77. PRE-CERTIFICATION** – First Priority Life may add or delete services, which require Pre-Certification, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan at the address on the records of First Priority Life at least thirty (30) days in advance of such change.
- 78. PRIVATE DUTY NURSING** – Total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.
- 79. 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
- 80. 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.
- 81. PROVIDER** – A Facility Provider, Professional Provider, Pharmacy Provider, or Supplier licensed, where required, and performing services within the scope of such license.

PREFERRED PROVIDER – A Provider who has signed a Provider Agreement with First Priority Life and/or

Highmark Blue Shield, as applicable, and/or has signed a Provider Agreement with and is a member of the Host Blue PPO Network designated for use under the BlueCard program.

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

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

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

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

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

- **NON-PREFERRED PROFESSIONAL PROVIDER** – A Professional Provider who does not have a Provider Agreement with First Priority Life and/or Highmark Blue Shield, as applicable, and who has not signed a Provider Agreement with and is not a member of the Host Blue BlueCard PPO Network nor is otherwise designated by a Host Blue as a “Participating Provider” under the BlueCard program. When services are provided by a Non-Preferred Professional Provider, coverage will be provided at the Non-Preferred Provider level, with the exception of Emergency Care.
82. **PROVIDER AGREEMENT** – An agreement between a Provider and First Priority Life and/or Highmark Blue Shield, as applicable, or any other Blue Plan (Host Blue) pursuant to which negotiated rates are established for payment of Covered Services rendered to Participant.
 83. **PSYCHIATRIC CARE** – Direct or consultative service provided by a Physician who specializes in psychiatry.
 84. **PSYCHIATRIC HOSPITAL** – A Facility Provider, approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.
 85. **PSYCHOLOGICAL CARE** – Direct or consultative services provided by a Psychologist.
 86. **PSYCHOLOGIST** – A licensed clinical Psychologist.
 87. **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.
 88. **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.
 89. **REHABILITATION HOSPITAL** – A Facility Provider approved by the appropriate accrediting agency or a similar accrediting agency acceptable to First Priority Life, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.
 90. **REHABILITATIVE CARE** – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
 91. **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.
 92. **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.

- 93. 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
- 94. SERVICE AREA** – The following thirteen (13) Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.
- 95. SKILLED NURSING FACILITY** – A Facility Other Provider, which is an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental disorders, alcoholism or drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested.
- 96. 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.
- 97. SUBSTANCE ABUSE TREATMENT FACILITY** – A licensed Facility Provider, which is primarily engaged in Detoxification and/or rehabilitation treatment for Alcohol and/or Drug Abuse. The Facility Provider must meet the minimum standards for such facilities set by the Pennsylvania Department of Health.
- 98. SUPPLIER** – An individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.
- 99. SURGERY** – The performance of generally accepted operative and cutting procedures, including specialized instrumentations, endoscopic examinations and other procedures; the correction of fractures and dislocations; and usual and related pre-operative and post-operative care.
- 100. THERAPEUTIC CARE** – Services provided by Speech Language Pathologists, Occupational Therapists or Physical Therapists.
- 101. THERAPY SERVICE** – Services or supplies used for the treatment of an illness or injury to promote the recovery of a Participant. Therapy Services are covered to the extent specified in the Agreement.
- a. **CARDIAC REHABILITATION THERAPY** – An exercise program, which is effective in the physiological and psychological rehabilitation of patients with cardiac conditions.
 - b. **COGNITIVE REHABILITATION THERAPY** – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain injury.
 - c. **DIALYSIS TREATMENT** – The treatment of acute renal failure or chronic irreversible renal insufficiency or removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
 - d. **OCCUPATIONAL THERAPY** – The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
 - e. **PHYSICAL THERAPY** – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part performed by a licensed Physical Therapist.

- f. **PULMONARY REHABILITATION THERAPY** – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders.
- g. **RADIATION THERAPY** – The treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- h. **RESPIRATORY THERAPY** – The introduction of dry or moist gases into the lungs for treatment purposes.
- i. **SPEECH THERAPY** – The treatment for the correction of a speech impairment resulting from disease, Surgery, injury, anomalies or previous therapeutic processes.

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

103. TREATMENT PLAN FOR ASD – A plan for the treatment of Autism Spectrum Disorders developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

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

SECTION SE – SCHEDULE OF ELIGIBILITY

A. ELIGIBILITY

At the direction of the Plan, a person will be enrolled in accordance with the Plan's specific eligibility requirements.

B. DEPENDENT ELIGIBILITY

1. At the direction of the Plan, to be eligible to enroll as a Dependent, a person must be: a) the spouse of a Participant; or b) the Participant or Participant's spouse's unmarried child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order. First Priority Life with approval from the Plan may require legal written documentation to verify the relationship between a Dependent and the Participant.

Dependent children must be:

- a. At the direction of the Plan, Less than the age specified under the student age limitation on **the Outline of Coverage**. Coverage will continue until the end of the period specified in **the Outline of Coverage** in which the Dependent reaches the specified age or until the end of the premium payment period following the date in which such Dependent marries or becomes employed in self-sustaining employment, whichever occurs first; or
- b. At the direction of the Plan, Nineteen (19) years of age or older but incapable of self-support due to mental retardation or physical disability, either of which commenced prior to age nineteen (19); and has been continuously present from then and has been certified by a Physician who is knowledgeable of the Dependent's present condition; or

- c. At the direction of the Plan, Unmarried children under the age specified in **the Outline of Coverage** who are Full-Time Students dependent solely upon the Participant or Participant's spouse for support. Except as set forth below, coverage will continue until the end of the period specified in **the Outline of Coverage** or until the end of the premium payment period following the date in which such child ceases to be a Full-Time Student, marries or becomes employed full-time, whichever occurs first. Except, however, eligibility shall be extended to Full-Time Students who remain eligible for coverage as dependent children under this Policy and shall not terminate when a Full-Time Student is required to take a medically necessary leave of absence before the date that is the earlier of:
 - the date that is one year after the first day of the medically necessary leave of absence; or
 - the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.
- d. House Bill 2851 ("Michelle's Law") defines a Medically Necessary leave of absence as being a leave from school or any other change in enrollment that commences while the child is suffering from a serious illness or injury, is medically necessary, and causes such child to lose student status for purposes of coverage under the terms of their health plans/coverage. At the direction of the group First Priority Life will enroll the eligible Participant.

The term "full-time" does not include those students attending night school or summer school only, or those attending school on a part-time basis.

- e. At the direction of the Plan, Eligibility shall continue past the limiting age for unmarried children who are incapable of self sustaining employment due to mental retardation, physical handicap, mental illness or developmental disability if such disability commenced while the child was a validly enrolled under the Participant as a Dependent and has been certified as disabled by First Priority Life and the Plan. If a disabled dependent child is covered under a parent at the time this language becomes effective, the disabled Dependent will be eligible for coverage under the Participant as long as he/she is certified as a disabled Dependent by First Priority Life and the Plan.
2. At the direction of the Plan, Newborn children as specified in **the Outline of Coverage** will be treated as Dependents from birth subject to enrollment requirements. Coverage shall include sickness or injury, including medically diagnosed congenital defects, birth abnormalities, pre-maturity, and routine nursery care. 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. To continue coverage for the child beyond the thirty-one (31) day period by enrolling the newborn child as a dependent within thirty-one (31) days following the birth of the child.
 3. The determination of eligibility will be made by the Plan.

SECTION CC – CARE COORDINATION

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

A. SELECTION OF PROVIDERS

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

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

B. EMERGENCY SERVICES

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

C. MEDICALLY NECESSARY SERVICES

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

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

D. EXPERIMENTAL/INVESTIGATIVE TREATMENT

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

E. TO REQUEST PRE-CERTIFICATION

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

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

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

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

Pharmacy Management Department
First Priority Life

F. PRE-CERTIFICATION OF SERVICES

1. Services

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

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

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

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

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

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

2. Providers

Although a Provider should obtain Pre-Certification on behalf of a Participant, the Participant is ultimately responsible for obtaining the Pre-Certification and should check with their Provider or the Pre-Certification Department of First Priority Life prior to the service being rendered.

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

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

Non-Preferred Providers: The Participant is responsible for obtaining the required Pre-Certification for use of Non-Preferred Providers. A Non-Preferred Provider is not obligated to accept First Priority Life's determination, and therefore, may bill the Participant for services initially determined not to be Medically Necessary. The Participant may be solely responsible for payment for such services. The Participant can avoid this responsibility by choosing a Preferred Provider or a Non-Preferred Participating Provider.

3. Penalty

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

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

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

First Priority Life only covers services, which it initially determines to be Medically Necessary. Should the Participant fail to obtain Pre-Certification from a Non-Preferred Provider, as required, and it is initially determined that the service was not Medically Necessary, the Participant may be liable for the full cost of any services rendered.

G. CONCURRENT REVIEW

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

H. CASE MANAGEMENT

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

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

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

SECTION SB – SCHEDULE OF COVERED SERVICES FOR MEDICAL EXPENSES

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

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

COPAYMENT – The amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth on **the Outline of Coverage**. Copayments for procedures for the surgical treatment of Morbid Obesity and for a panniculectomy are set forth in the Description of Covered Services Section.

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

DEDUCTIBLE (Non-Preferred Participating/Non-Preferred Provider) – Unless otherwise noted, the Deductible applies to all Covered Services, including Inpatient services and supplies resulting from an accident or Medical Emergency. Services to which the Deductible does not apply are as follows: Outpatient Emergency Accident/Medical Services, emergency ambulance, pediatric and childhood immunizations, routine gynecological examinations and Pap Smears, postpartum home health care visit, Metabolic Formulas, mammograms, routine colon cancer screenings, and routine prostate cancer screenings. Amounts incurred toward the Non-Preferred Participating/Non-Preferred Provider Deductible will also be applied to the Preferred Provider Deductible. **The Outline of Coverage specifies the Deductible amount.**

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

COINSURANCE (Preferred Provider) is specified in **the Outline of Coverage**. For the removal of bony impacted wisdom teeth and Ostomy Supplies, the Coinsurance is paid at **50%** of the Allowable Charge or as stated in **the Outline of Coverage**. Coinsurance applies to all Covered Medical Expenses when a Copayment is not applicable. Coinsurance also does not apply to the postpartum home health care visit.

COINSURANCE (Non-Preferred Participating/Non-Preferred Provider) is specified in **the Outline of Coverage**. Coinsurance applies to all Covered Medical Expenses with the exception of the postpartum home health care visit and when a Copayment is not applicable. Covered Services provided by a Non-Preferred Participating/Non-Preferred Provider for Outpatient emergency accident services and emergency medical services are payable at a rate at which the Participant will not incur a greater out-of-pocket expense than would had been incurred had the Participant been able to choose a Preferred Provider.

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

The Maximum amount of Coinsurance for each of three (3) separate family members that will be applied per Benefit Period is specified in **the Outline of Coverage**.

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

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

The Maximum amount of Coinsurance for each of three (3) separate family members that will be applied per Benefit Period is specified in *the Outline of Coverage*.

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

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

FAMILY COINSURANCE MAXIMUM (Preferred Provider and Non-Preferred Participating/Non-Preferred Provider) – The Maximum of Coinsurance applied for each of three (3) separate family members in a Benefit Period is specified in *the Outline of Coverage*.

The eligible Coinsurance amounts, which are incurred by three (3) separate family members covered under the Agreement, may be contributed to the family Coinsurance Maximum. When three (3) separate Participants covered under the same Family Coverage have incurred the Coinsurance Maximum for a family for a Benefit Period, which is three (3) times the amount for an individual, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period, except for the removal of bony impacted wisdom teeth and Ostomy Supplies when the services are performed by a Preferred Provider which is paid at **50%** of the Allowable Charge or as stated in *the Outline of Coverage*.

No one family member's Coinsurance may exceed the individual limits. Deductible and Coinsurance amounts for family members that did not satisfy the individual limits will not be refunded in the event the family Deductible or family Coinsurance Maximum is met by three (3) separate family members.

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

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

MEDICAL LIFETIME BENEFIT MAXIMUM (Preferred Provider) – per lifetime limit as indicated on *the Outline of Coverage*, per Participant.

MEDICAL LIFETIME BENEFIT MAXIMUM (Non-Preferred Participating/Non-Preferred Provider) is specified in *the Outline of Coverage*. It is per lifetime, per Participant.

Amounts applied to the Participant's Lifetime Benefit Maximum are not restorable.

CROSS PRODUCT ACCUMULATION – If a Participant changes products offered by First Priority Life, its affiliated companies (Blue Cross of Northeastern Pennsylvania, Highmark Blue Shield, or First Priority Health) while with the same Policy Holder during a Benefit Period, or if a Participant changes Deductibles during a Benefit Period while with the same Agreement, eligible expenses, which were applied to the original Deductible and Coinsurance Maximum,

will be eligible for credit towards the new Deductible and Coinsurance Maximum amounts during the remainder of that same Benefit Period. Cross Product Accumulation will apply to the Preferred Provider Deductible and Coinsurance Maximum amounts.

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

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

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

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

PRIOR CARRIER CREDIT – If the Plan changes carriers during a Plan's Benefit Period, Covered Expenses which were incurred and applied to the Deductible and Coinsurance Maximum by the prior carrier during such Benefit Period shall be credited by First Priority Life toward the initial Benefit Period under this new Agreement for those Eligible Employees and Dependents who are enrolled with the Plan during the initial Benefit Period. Prior Carrier Credit will be applied to the Preferred Provider Deductible and Coinsurance Maximum amounts only.

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

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

SECTION DB – DESCRIPTION OF COVERED SERVICES

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

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

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

A. HOSPITAL SERVICES

1. Room and Board

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

- a. a Semi-Private Room, as designated by the Hospital; or a private room, when designated by First Priority Life as semi-private for the purposes of the Agreement, in Hospitals having primarily private rooms;
- b. a private room. The private room allowance is the Semi-Private Room charge;
- c. a special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
- d. a bed in a general ward; and
- e. nursery facilities.

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

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

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

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

2. Ancillary Services

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

- a. meals, including special meals or dietary services as required by the patient's condition;
- b. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- c. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by First Priority Life;
- d. oxygen and oxygen therapy;
- e. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Subsection Y - Blood and Blood Plasma of this Section;
- f. anesthesia and the supplies and use of anesthetic equipment;
- g. Diagnostic Services;
- h. Therapy Services;
- i. Inpatient rehabilitation therapy limited to forty-five (45) or as specified on **the Outline of Coverage** days per Benefit Period;

- j. all FDA-approved drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;
- k. use of special care units, including, but not limited to, intensive or coronary care; and
- l. pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a diagnosis. Covered Services for pre-admission testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancels or postpones the admission, Covered Services will be provided.

B. OBSERVATION STATUS

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

C. EMERGENCY CARE COVERED SERVICES

Emergency care Covered Services include treatment and services in the Outpatient department of a Hospital and Hospital services and supplies for an Inpatient admission resulting from an accident or Medical Emergency.

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

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

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

First Priority Life reserves the right to initially determine, on the basis of the severity of symptoms, diagnosis and supporting medical data, whether the services received by the Participant are eligible for Covered Services under this Subsection C.

D. SURGERY

1. Surgical Covered Services

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

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

- Upon Pre-Certification, Surgery Covered Services are covered for the surgical treatment of Morbid Obesity, provided the Participant is at least eighteen (18) years of age and has no prior history of bariatric Surgery. If the preferred Coinsurance on **the Outline of Coverage** indicates “none,” a Copayment of \$2,000 applies for the procedure when performed by a Preferred Provider or as indicated on **the Outline of Coverage**. Copayments are the responsibility of the Participant.
- When a panniculectomy is Medically Necessary, upon Pre-Certification it is limited to one (1) procedure per lifetime or as indicated on **the Outline of Coverage** for those eighteen (18) years of age or older. If the preferred Coinsurance on **the Outline of Coverage** indicates “none,” a Copayment of \$1,000 applies for the procedure when performed by a Preferred Provide or as indicated on **the Outline of Coverage**. Copayments are the responsibility of the Participant.
- Reconstructive Surgery will only be covered when required to restore function following accidental injury, infection, or disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of eighteen (18); or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy.
- Covered surgical procedures shall also include routine neonatal circumcision or as indicated on **the Outline of Coverage**. Voluntary surgical procedures for sterilization regardless of Medical Necessity and Surgery performed for the reversal of sterilization are not covered or as indicated on **the Outline of Coverage**.
- Covered Services are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:
 - a. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
 - b. Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
 - c. Physical complications of all stages of Mastectomy, including lymphedemas.

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

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

2. Assistant Surgeon

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

3. Removal of Bony Impacted Wisdom Teeth

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

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

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

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

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

Local anesthesia and conscious sedation are covered regardless of setting.

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

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

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health, or
- When one of the following is present:
 - a. It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
 - b. There is non-dental disease eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Participant's teeth.
 - c. There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant.

5. Oral Surgery

Oral Surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Service only for treatment of diseases and injuries of the jaw, head and neck. Surgery for the treatment of diseases of the teeth or gums, are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions.

Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures are excluded from Covered Services for oral Surgery unless such procedures were for the treatment of accidental bodily injury or as described in Subsection D, Paragraph 4 above.

6. Dental Services related to Accidental Injury

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

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

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

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

E. ANESTHESIA

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

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

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

- Children under the age of eighteen (18), or
- Adults with significant cognitive impairment, or
- Participants with complex medical conditions, when performing the surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health, or
- When one of the following is present:
 - a. It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
 - b. There is non-dental diseases eroding or invading the maxilla and/or mandible, the treatment of which necessitated removal of the Insured Person's teeth.
 - c. There is infection of the teeth and gums that places the Insured Person's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to chemotherapy or transplant.

Local anesthesia and conscious sedation are covered regardless of setting.

F. SECOND SURGICAL OPINION

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

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

G. TRANSPLANT SURGERY

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

1. When both the recipient and the donor are Participants, each is entitled to the Covered Services of the Agreement.
2. When only the recipient is a Participant, both the donor and the recipient are entitled to the Covered Services of the Agreement. The donor Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to: other insurance coverage, or coverage by First Priority Life or any government program. Covered Services provided to the donor will be charged against the recipient's coverage under the Agreement to the extent Covered Services remain and are available under the Participant after the Covered Services of the recipient have been paid.
3. When only the donor is a Participant, the donor is entitled to the Covered Services of the Agreement. The Covered Services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by First Priority Life or any government program available to the recipient. No Covered Services will be provided to the non-Participant transplant recipient.
4. If any organ or tissue is sold rather than donated to the Participant recipient, no Covered Services will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Participant recipient's Agreement limit.
5. If the Participant's coverage includes Prescription Drug coverage, the immunosuppressant drugs in connection with covered transplants will be provided under the Prescription Drug Coverage Section of the Agreement and the cost for these drugs is detailed in ***the Outline of Coverage***.

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

H. CONCURRENT CARE

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

I. CONSULTATIONS

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

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

J. PHYSICIAN OFFICE VISITS

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

K. THERAPEUTIC DRUGS THAT ARE NOT SELF-ADMINISTRABLE

Covered Services are provided for FDA-approved therapeutic drugs, including cancer Chemotherapy and cancer

hormone treatment that are not self-administrable and required in the treatment of an illness or injury in all medically appropriate treatment settings covered by the Agreement.

L. DIAGNOSTIC SERVICES-OUTPATIENT

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

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

Diagnostic mammograms, which are recommended by a Physician, are covered for all Participants. Diagnostic mammograms are subject and are exempt from all Deductibles and Maximums.)
2. Diagnostic laboratory and pathology tests.
3. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life.
4. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan, and nuclear cardiology studies approved by First Priority Life. If the preferred coinsurance on **the Outline of Coverage** indicated "none", a Copayment of **\$75** may apply per test/scan per **the Outline of Coverage**.

If the diagnostic imaging procedure is rendered in conjunction with an Outpatient emergency room visit, Inpatient admission, observation status, or ambulatory surgical procedure, the **\$75** Copayment per test/scan will be waived.
5. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

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

M. THERAPY SERVICES-OUTPATIENT

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

1. Cardiac Rehabilitation Therapy is limited to a Maximum of thirty-six (36) visits or as indicated on **the Outline of Coverage** per Benefit Period.
2. Dialysis Treatment.
3. Pulmonary Rehabilitation Therapy is limited to a Maximum of eighteen (18) visits or as indicated on **the Outline of Coverage** per Benefit Period.
4. Radiation Therapy, including the cost of radioactive materials.
5. Respiratory Therapy is limited to a Maximum of eighteen (18) visits or as indicated on **the Outline of Coverage** per Benefit Period.
6. Short term therapy is Occupational, Physical, or Speech Therapy which:
 - is prescribed by a Physician,
 - is Medically Necessary to regain lost function after an accidental injury, Surgery, or an acute illness, and

- will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

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

- (a) Occupational Therapy is limited to a Maximum of twelve (12) visits or as indicated on **the Outline of Coverage** per Benefit Period.
- (b) Physical Therapy is limited to a Maximum of twenty (20) visits or as indicated on **the Outline of Coverage** per Benefit Period.
- (c) Speech Therapy is limited to a Maximum of twelve (12) visits or as indicated on **the Outline of Coverage** per Benefit Period.

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

N. MATERNITY SERVICES

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

1. Normal Pregnancy

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

2. Complications of Pregnancy

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

3. Minimum Length of Stay

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

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. The postpartum home health visit is exempt from any Deductibles, Copayments or

Coinsurance.

4. Interruptions of Pregnancy

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

5. Nursery Care

Ordinary nursery care of the newborn infant.

6. Routine Newborn Care

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

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

Routine neonatal circumcision is covered.

O. ARTIFICIAL INSEMINATION

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

P. MENTAL HEALTH CARE SERVICES

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

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

1. Inpatient Services

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

2. Outpatient Services

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

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

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

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

Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Drug and Alcohol treatment by non-Physicians/Psychologists must be pre-certified with CBHNP before services are rendered and must meet Medical Necessity criteria.

1. Inpatient Detoxification

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

- a. lodging and dietary services;
- b. rehabilitation therapy and counseling;
- c. diagnostic x-ray;
- d. psychiatric, psychological and medical laboratory testing; and
- e. drugs, medicines, equipment use and supplies.

2. Inpatient Non-Hospital Residential Care

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

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

- a. lodging and dietary services;
- b. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
- c. rehabilitation therapy and counseling;
- d. family counseling and intervention;
- e. psychiatric, psychological and medical laboratory testing; and

- f. drugs, medicines, equipment use and supplies.

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

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

- a. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
- b. rehabilitation therapy and counseling;
- c. family counseling and intervention;
- d. psychiatric, psychological and medical laboratory testing; and
- e. drugs, medicines, equipment use and supplies.

R. OXYGEN AND RELATED EQUIPMENT/SUPPLIES

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

S. SKILLED NURSING FACILITY

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

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

No Covered Services are payable:

1. after the Participant has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care;
2. when confinement in a Skilled Nursing Facility is intended solely to assist the Participant with the activities of daily living or to provide an institutional environment for the convenience of a Participant; or
3. for the treatment of alcoholism, drug addiction, or mental illness.

T. HOME HEALTH CARE

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

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

1. professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;
2. home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;

3. Physical Therapy treatments performed by a licensed Physical Therapist;
4. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;
5. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;
6. medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;
7. Nutritional Therapy provided by a Licensed Dietitian;
8. diagnostic and therapeutic radiology services;
9. laboratory services;
10. medical diagnostic tests and studies;
11. oxygen and Respiratory Therapy;
12. medical and surgical supplies, including bandages, ostomy supplies, dressings and casts²; and
13. the rental of Durable Medical Equipment but only on a short term basis and if not owned by the Home Health Care Agency.

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

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

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

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

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

² Durable Medical Equipment/Prostheses/Orthoses or Ostomy Supplies provided to a Homebound Insured as part of Home Health Care will not reduce the benefit provided. Under Subsection EE, Durable Medical Equipment/Prostheses/Orthoses or Subsection FF, Ostomy Supplies of the Description of Benefits Section of this Policy.

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

No home health care Covered Services will be provided for:

1. food or home delivered meals;
2. professional medical services billed by a Physician;
3. Custodial Care;
4. services of a housekeeper;
5. Private Duty Nursing;
6. ambulance service;
7. drugs, including Prescription Drugs; and
8. services provided by Immediate Family or members of the Participant's household.

U. HOME INFUSION THERAPY

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

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

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

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

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

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

Home Infusion Therapy Covered Services will not be provided for:

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

V. METABOLIC FORMULAS

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

W. HOSPICE CARE

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

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

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

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

1. professional services of a Registered Nurse or Licensed Practical Nurse;
2. pain management;
3. Chemotherapy and/or Radiation Therapy;
4. parenteral or enteral nutrition therapy;
5. prescription drugs;
6. laboratory services;
7. dietitian services;

8. medical and surgical supplies, ostomy supplies, and Durable Medical Equipment³;
9. oxygen and its administration;
10. medical social service consultation provided by a social worker;
11. counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
12. home health aide and homemaker services; and
13. any needed therapies.

X. DIABETES EDUCATION/EQUIPMENT/SUPPLIES

Diabetes Education

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

Diabetic Equipment and Supplies

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

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

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

³ Durable Medical Equipment/Prostheses/Orthoses or Ostomy Supplies provided to a Participant as part of Hospice Care will not reduce the Covered Services provided under Subsection EE, Durable Medical Equipment/Prostheses/Orthoses or Subsection FF, Ostomy Supplies of the Description of Covered Services Section of the Agreement.

Provider.

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

Y. BLOOD AND BLOOD PLASMA

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

Z. AMBULANCE SERVICES

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

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

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

AA. PREVENTIVE CARE

Covered Services will be provided for Covered Services as outlined in ***the Outline of Coverage***.

1. Routine Pediatric Care

Pediatric care includes routine physical examinations. Covered Services are limited to Participants under eighteen (18) years of age in accordance with a pre-defined schedule. *

2. Routine Adult Care

Adult care includes routine physical examinations, including a complete medical history plus necessary Diagnostic Services. Covered Services are limited to Participants eighteen (18) years of age and older in accordance with a pre-defined schedule. *

**This schedule is reviewed and updated periodically by First Priority Life based upon the recommendations of the American Academy of Pediatrics, U.S. Preventive Services Task Force, and the Blue Cross and Blue Shield Association. Accordingly, the frequency and eligibility of services are subject to change.*

3. Immunizations

Coverage will be provided for those pediatric immunizations, including immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Childhood immunizations are available until the Participant attains age twenty-one (21). Covered Services for childhood immunizations are exempt from Deductibles and Benefit Maximums.

Covered Services are also provided for other immunizations, including immunizing agents, which are determined to be Medically Necessary. Immunizations required solely for international travel or work are not covered.

4. 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 Benefit Maximums or as indicated on ***the Outline of Coverage***.

5. Screening Mammograms

Screening mammograms are covered for all Participants age forty (40) or over whether or not directed toward a definite condition of disease or injury. Covered Services are exempt from all Deductibles and Benefit Maximums or as indicated on ***the Outline of Coverage***.

Covered Services for mammography screening are payable only if performed by a mammography service provider who is properly licensed by the Department of Health.

6. Colorectal Cancer Screening and Prostate Cancer Screening

Colorectal Cancer Screening

Coverage for colorectal cancer screening is provided for covered individuals in accordance with the American Cancer Society guidelines for colorectal cancer screening published as of January 1, 2008, and consistent with approved medical standards and practices.

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

Coverage for non-symptomatic covered individuals who are fifty (50) years of age or older shall include, but is not limited to:

- i. An annual fecal occult blood test.
- ii. A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.
- iii. A colonoscopy at least once every ten (10) years.

Coverage for non-symptomatic covered individuals who are at high or increased risk for colorectal cancer who are under fifty (50) years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008, and consistent with approved medical standards and practices.

Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles.

Prostate Cancer Screening

Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal exam per Benefit Period. Covered Services are exempt from all Deductibles or as indicated on ***the Outline of Coverage***.

BB. ALLERGY EXTRACTS/INJECTIONS

Covered Services are provided for allergy extracts and antigen injections.

CC. NUTRITIONAL THERAPY

Nutritional Therapy is available to Participants when provided by a Licensed Dietitian up to the Maximum of **six (6) visits** per Participant per Benefit Period or as stated in ***the Outline of Coverage***. The Participant is responsible for a Copayment of **\$10** per visit or as stated in ***the Outline of Coverage***. Diabetes Outpatient self-management training and education as provided in Subsection X of this Description of Covered Services Section and Nutritional Therapy provided to a Homebound Participants under Subsection T of this Description of Covered Services Section are exempt from this Benefit Maximum or as indicated on ***the Outline of Coverage***.

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

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

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

DD. CHIROPRACTIC MANIPULATIVE COVERED SERVICES

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

EE. DURABLE MEDICAL EQUIPMENT/PROSTHESES/ORTHOSES

Eligible expenses incurred within a Benefit Period are limited to a Maximum payment as set forth in ***the Outline of Coverage***, except those equipment and supplies prescribed as a result of diabetes pursuant to Subsection X, Diabetes Education/Equipment/Supplies, Prostheses prescribed as a result of a Mastectomy as set forth in Subsection D, Surgery, and Ostomy Supplies as set forth in Subsection FF, Ostomy Supplies of the Description of Covered Services Section of the Agreement are excluded from this limit. Except for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, replacements are not included, other than as certified as Medically Necessary for children due to normal growth process.

Instructions regarding appropriate use of the item are covered.

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

- a. hospital beds and related equipment (bed rails, mattresses);
- b. equipment to increase mobility (walkers, wheelchairs);
- c. commodes (elevated seats, portable bedside commodes);
- d. breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);
- e. therapeutic equipment;

- f. apnea monitors;
- g. Jobst pressure garments used in burn treatment; and
- h. Unna boots and air casts.

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

- a. artificial limbs;
- b. knee braces, not made of elastic or fabric support;
- c. splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or "figure-8", finger, Pavlik harness and wrist);
- d. immobilizers;
- e. corrective shoes, shoe inserts and supports, and/or other foot Orthoses;
- f. supportive back braces with metal stays;
- g. dynasplints;
- h. cryocuffs; and
- i. eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e., cataract Surgery) or injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:
 - 1) contact lenses used for treatment of infantile glaucoma;
 - 2) corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
 - 3) scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 - 4) corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

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

Covered Services are not payable for dental appliances, wigs, or eyeglasses, except as specified in item i for eyeglasses or lenses immediately above.

FF. OSTOMY SUPPLIES

Covered Ostomy Supplies include and are limited to the following:

- a. ostomy appliances and supplies specifically relating to an ostomy (colostomy, ileostomy, urostomy or tracheostomy) are limited to: collection devices, irrigation equipment and supplies, skin barriers and skin protectors.
- b. urinary catheters, both reusable or disposable, whether or not used in conjunction with an ostomy.

Ostomy Supplies are covered as specified in Section SB – Schedule of Covered Services for Covered

Medical Expenses up to a maximum of **\$1,000** per Insured per Benefit Period or as indicated in *the Outline of Coverage*. Coverage is limited to supplies obtained from Preferred Providers.

GG. AUTISM SPECTRUM DISORDERS

The Outline of Coverage specifies Autism Spectrum Disorder coverage and how it applies. When Autism Spectrum Disorder coverage is applicable, refer to the following:

For Participants under twenty-one (21) years of age or as indicated on the ***Outline of Coverage***, coverage will be provided for the diagnostic assessment of Autism Spectrum Disorders and for the treatment of Autism Spectrum Disorders up to a Maximum benefit of **\$36,000*** or as indicated on the ***Outline of Coverage*** per Participant per Benefit Period. Once the Benefit Period Maximum has been reached, no additional Covered Services are available under the agreement for the remainder of the Benefit Period for the diagnostic assessment and/or treatment of the Participant's Autism Spectrum Disorder. When a Provider renders Medical Care for treatment of a health condition unrelated to or distinguishable from the Participant's Autism Spectrum Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be applied toward this dollar Maximum.

No coverage is provided for Participants age twenty-one (21) and over or as indicated on the ***Outline of Coverage***.

Treatment of Autism Spectrum Disorders shall be identified in a Treatment Plan for ASD and shall include any of the following Medically Necessary services: Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care, and Therapeutic Care that is:

- i. Prescribed, ordered or provided by a licensed Physician, licensed Physician Assistant, licensed Psychologist, licensed clinical Social Worker, or certified Registered Nurse Practitioner.
- ii. Provided by an Autism Service Provider.
- iii. Provided by a person, entity or group that works under the direction of an Autism Service Provider.

The treatment plan should be developed by a physician or psychologist, following a comprehensive evaluation consistent with current recommendations of the American Academy of Pediatrics. The treatment plan may be reviewed once every six (6) months, subject to Blue Cross' utilization review requirements, including case management, concurrent review and other managed care provisions. A more or less frequent review can be agreed upon by Blue Cross and the physician or psychologist developing the treatment plan. The provider is responsible for maintaining a copy of the autism assessment and treatment plan, to be made available upon request.

* After December 31, 2011, the Pennsylvania Insurance Commissioner shall publish in the Pennsylvania Bulletin an adjustment to the Autism Spectrum Disorder Maximum, equal to the change in the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U), to be applicable to the following Calendar Year. The Autism Spectrum Disorder Maximum shall be adjusted effective January 1 of the following Calendar Year.

The ***Outline of Coverage*** specifies whether Prescription Drug coverage applies.

If the Participant's coverage includes Prescription Drug coverage, the Participant is responsible for the applicable Copayment, Coinsurance, and/or Deductible, if any, for each Prescription prescribed for the treatment of Autism Spectrum Disorder. The Copayment, Coinsurance, and/or Deductible, if any, are paid by the Participant directly to the Pharmacy for each Prescription. The Outline of Coverage specifies the Copayment, Coinsurance, and/or Deductible amounts.

HH. Experimental or Investigative Services

A Medical Director of First Priority Life shall determine whether the use of any treatment, procedure, Provider equipment, drug, device, or supply (each of which is hereafter called a "Service") is Experimental or Investigative (that is not supported by evidence-based medicine).

1. If, in making that determination, a Medical Director of First Priority Life finds that the service, for which a claim for covered services is made, is either, (1) the subject of a written investigational or research protocol used by the treating Provider or of a written investigational or research protocol of another Provider studying substantially the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental, Investigative, educational, or research; or (3) the subject of an on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative.
2. If, in making that determination, a Medical Director of First Priority Life finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then a Medical Director of First Priority Life may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:
 - a. the technology must have final approval from the appropriate governmental regulatory bodies;
 - b. the scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
 - c. the technology must improve the net health outcome;
 - d. the technology must be as beneficial as any established alternatives; and
 - e. the improvement must be attainable outside the investigational settings.

PEER REVIEW MEDICAL LITERATURE means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledge experts inside or outside the editorial office in their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publications.

3. If, in making the determination, a Medical Director of First Priority Life finds that a drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is received; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the drug, device, supply, or equipment shall be deemed to be Experimental or Investigative.

The Outline of Coverage specifies if Prescription Drug coverage applies. When Prescription Drug coverage is applicable, refer to the following provisions.

SECTION Rx – PRESCRIPTION DRUG COVERAGE

A. DEFINITIONS

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

1. **COVERED PHARMACY EXPENSE** – A service or supply specified in the Agreement for which Covered Services for Prescription Drugs and supplies will be provided pursuant to the terms of the Agreement.
2. **DRUG FORMULARY** – A listing of Preferred Prescription Drugs and supplies covered by First Priority Life, which is subject to periodic review and modification at least annually by a committee of appropriate actively practicing preferred Physicians and Pharmacists. Prescription Drug inclusions in the Drug Formulary are based on a combination of criteria including clinical quality and cost effectiveness. The Participant will receive a copy of the Drug Formulary with the Certificate of Coverage. The Drug Formulary is available upon request from Express Scripts Service Representatives by calling toll-free 1-877-603-8399 or via First Priority Life’s website, www.bcnepa.com.
3. **GENERIC EQUIVALENT PRESCRIPTION DRUG** – Any Prescription Drug that is considered to be therapeutically equivalent to other pharmaceutical equivalent products by the Food and Drug Administration, has received an “A Code” in the FDA “Approved Drug Products with Therapeutic Equivalence Evaluations,” and is in compliance with applicable state generic substitution laws and regulations.
4. **MAINTENANCE PRESCRIPTION DRUG** – Any Prescription Drug, not including Specialty Injectable Drugs, which First Priority Life makes available through a Participating Mail Order Pharmacy, which is generally used to treat chronic medical conditions and is generally not needed urgently for an immediate acute illness and which the Participant chooses to obtain, or First Priority Life requires be obtained, from a Participating Mail Order Pharmacy. First Priority Life may specify certain Prescription Drugs that are not available through a Participating Mail Order Pharmacy.
5. **NON-PREFERRED PRESCRIPTION DRUG** – Any Prescription Drug listed in Tier 3 of the First Priority Life Drug Formulary available with a Tier 3 Copayment.
6. **PARTICIPATING COMMUNITY PHARMACY PROVIDER** – Any Participating Pharmacy Provider, which is a public, walk-in Pharmacy.
7. **PARTICIPATING MAIL ORDER PHARMACY PROVIDER** – A Participating Pharmacy, which has entered into a Participating Mail Order Pharmacy agreement with First Priority Life.
8. **PARTICIPATING PHARMACY PROVIDER** – Any Pharmacy, which has entered into a Participating Pharmacy agreement with First Priority Life or other entity contracted by First Priority Life to furnish a Pharmacy Provider network. Participating Pharmacy Providers include: Participating Community Pharmacy Providers, Participating Mail Order Pharmacy Providers and Participating Pharmacy Providers for Specialty Drugs.
9. **PARTICIPATING PHARMACY PROVIDER FOR SPECIALTY DRUGS** – A Participating Pharmacy Provider, which has entered into a Specialty Drug Provider Agreement with First Priority Life.
10. **PHARMACIST** – An individual who has been issued a license by the appropriate state licensing agency to engage in the practice of pharmacy, including the preparation and dispensing of Prescription Drugs and the dissemination of drug information to patients and health professionals.
11. **PHARMACY** – An establishment which has been issued a permit by the appropriate state licensing agency wherein the practice of pharmacy is conducted under the direct supervision and control of a licensed Pharmacist.
12. **PREFERRED PRESCRIPTION DRUG** – Any Prescription Drug, which is listed in the Drug Formulary and preferred by First Priority Life. Preferred Prescription Drugs are those listed in Tier 0, Tier 1 or Tier 2 of the Drug Formulary.

13. **PRESCRIBER** – An individual who has been issued a license by the appropriate state licensing agency to engage in a health care professional practice, who, acting within the scope of his/her license, is duly authorized by law to prescribe Prescription Drugs.
14. **PRESCRIPTION** – An order from a Prescriber for a single Prescription Drug of a particular strength and/or dosage form.
15. **PRESCRIPTION DRUG** – Any medication, which by federal and/or state law may not be dispensed without a Prescription order issued by a Prescriber.
16. **PRESCRIPTION DRUG COINSURANCE** – The specific percentage of Covered Pharmacy expenses for which the Participant is responsible as set forth in ***the Outline of Coverage*** and in the ***Subsection B, Schedule for Covered Pharmacy Expenses***.
17. **PRESCRIPTION DRUG COINSURANCE MAXIMUM** – A specified dollar amount of Coinsurance that applies to Covered Pharmacy Expenses incurred by a Participant in a Benefit Period, as set forth in ***the Outline of Coverage***, and in the ***Subsection B, Schedule for Covered Pharmacy Expenses***.
18. **PRESCRIPTION DRUG COPAYMENT** – The amount a Participant must pay directly to Pharmacy Providers in connection with Covered Pharmacy Expenses as set forth in ***the Outline of Coverage***.
19. **PRESCRIPTION DRUG DEDUCTIBLE** – A specified amount of Covered Pharmacy Expenses, usually expressed in dollars as set forth in ***the Outline of Coverage*** that must be incurred by a Participant before First Priority Life will assume any liability for all or part of the remaining Covered Pharmacy Expenses.
20. **PRESCRIPTION DRUG MAXIMUM** – The greatest Covered Service amount payable by First Priority Life for Covered Pharmacy Expenses as set forth in ***the Outline of Coverage***.
21. **PRIOR AUTHORIZATION** – With regard to Prescription Drug Covered Services, Prior Authorization means the process whereby the Prescriber and/or the Participant is given prior approval by First Priority Life for certain Prescription Drugs, including Drug Formulary exceptions, and utilization review criteria, which have been designated by First Priority Life as requiring Prior Authorization.
22. **SPECIALTY DRUG** – Any Prescription Drug, which has been specifically designated by First Priority Life as being available from only a Participating Pharmacy for Specialty Drugs. Such Prescription Drugs classes include, but are not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech drugs. From time-to-time, such as when new biotech drugs become available, First Priority Life may specify certain Prescription Drugs that are available from only a Participating Pharmacy for Specialty Drugs.

B. SCHEDULE FOR COVERED PHARMACY EXPENSES

Except for special circumstances described in the following Subsection C, Prescription Drugs with Mail Order, Prescription Drugs dispensed by a non-participating Pharmacy are not covered. Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amount specified in ***the Outline of Coverage*** for one of the two options outlined below. Reimbursement will not exceed that set for the Generic Equivalent Drug. The difference in cost between the brand-name drug and the Generic Equivalent Drug will be payable by the Participant in addition to their Prescription Drug Copayment, Coinsurance and/or Deductible.

- There maybe a Copayment specific to self-administrable Prescription Drugs and supplies, excluding Specialty Drugs. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to

a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in ***the Outline of Coverage***. This Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Medical Expenses set forth in the Schedule of Covered Services for Covered Medical Expenses.

Based on ***the Outline of Coverage***, there may be Prescription Drug Coinsurance for Specialty Drugs payable directly to the Participating Pharmacy Provider for Specialty Drugs. There may be a **10%** Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of **\$3,000** per Participant per Benefit Period. Once the Coinsurance Maximum is reached per Participant per Benefit Period, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period.

or

- There may be a Prescription Drug Deductible per individual per Benefit Period as outlined in ***the Outline of Coverage*** for self-administrable Prescription Drugs and supplies, including Specialty Drugs.

Once the Prescription Drug Deductible is satisfied, there is a Copayment specific to self-administrable Prescription Drugs and supplies, excluding Specialty Drugs. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in ***the Outline of Coverage***. The Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Medical Expenses set forth above in the Schedule of Covered Services for Covered Medical Expenses.

Based on ***the Outline of Coverage***, once the Prescription Drug Deductible is satisfied, there is Prescription Drug Coinsurance for Specialty Drugs payable directly to the Participating Pharmacy Provider for Specialty Drugs. There may be a **10%** Coinsurance specific to Specialty Drugs up to a Prescription Drug Coinsurance Maximum of **\$3,000** per Participant per Benefit Period. Once the Coinsurance Maximum is reached per Participant per Benefit Period, the eligible Coinsurance percentage will be reduced to **0%** for the balance of the Benefit Period.

Unless otherwise stated, if the Participant's coverage does not include Prescription Drug coverage for each Prescription prescribed for the treatment of Autism Spectrum Disorder, there is a \$0 Tier 0, \$10 Tier 1, \$25 Tier 2, and \$45 Tier 3 Prescription Drug Copayment payable by the Participant directly to the Participating Pharmacy for each Prescription; there is a \$0 Tier 0, \$20 Tier 1, \$55 Tier 2, and \$135 Tier 3 mail order Prescription Drug Copayment payable by the Participant directly to the Participating Mail Order Pharmacy Provider.

C. PRESCRIPTION DRUGS WITH MAIL ORDER

Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified in the Outline of Coverage, as follows:

1. Covered drugs/supplies include: (a) Prescription Drugs which can be self-administered, including contraceptives for the use of birth control, ***if so specified in the Outline of Coverage***, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, sensors, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other drugs/supplies which may be specifically designated by First Priority Life, and (i) the covered pharmaceutical services necessary to make such drugs available, not including, however, any drug or group of drugs specifically excluded by the terms of the Agreement.
2. Reimbursement will not exceed that set for the Generic Equivalent Drug. The difference in cost between the brand-name drug and the Generic Equivalent Drug will be payable by the Participant in addition to their Prescription Drug Copayment.
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. 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.
7. All Prescription Drug claims are subject to prospective, concurrent and/or retrospective drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. Before prescribing the Prescription Drug, a Participating Prescriber will advise the Participant if Prior Authorization is required and request the Prior Authorization on behalf of the Participant. Participating Prescribers initially accept First Priority Life's determination of Medical Necessity. In the event the Prior Authorization is denied for lack of Medical Necessity, no Covered Services will be provided by First Priority Life when the Participant disregards the Prior Authorization denial and elects to purchase the Prescription Drug. Should a Prescription Drug, which requires Prior Authorization be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant prospectively that the claim was denied by First Priority Life because Prior Authorization is required for coverage of the Prescription Drug.

No Covered Services will be provided by First Priority Life when the Participant elects not to have the Participating Prescriber obtain Prior Authorization, disregards the Participating Pharmacy's notification of the claim denial and elects to purchase the Prescription Drug.

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: overutilization, drug-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.
- **The Outline of Coverage indicate whether oral contraceptives are covered.** 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 Section DB – Description of Covered Services, the following are excluded as Covered Pharmacy Expenses:
 - (1) drugs which do not require a Prescription; (2) drugs which cannot be self-administered; (3) medical supplies; devices and equipment, (4) test agents and devices, except those used for diabetes; (5) smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by First Priority Life which are covered for one treatment period per lifetime; (6) multiple vitamins, except those used for pregnancy and multiple vitamins with fluoride for the prevention of dental caries in children under the age of sixteen (16); (7) injectable drugs used to treat infertility; (8) the additional charge for a brand-name drug for which there is a Generic Equivalent Drug available; (9) drugs for impotence in excess of four doses per month; (10) allergy extracts for allergen immunotherapy; (11) administration or injection of any drugs; (12) replacement of lost, stolen or damaged drugs; (13) take home drugs dispensed by a Facility Provider or Professional Provider.