

FIRST PRIORITY HEALTH PLUS
The University of Scranton
Member Handbook

Your Benefits
And
How to Use Them

Use this space for information you'll need when asking about your coverage.

The company office or person to contact about coverage is:

Address: **The University of Scranton, Human Resources Dept.
Linden & Monroe Avenue
Scranton, Pa 18510-4679**

Phone: **(570) 941-7767**

The appropriate Blue Cross and Blue Shield Plan contact is:

Address: **First Priority Health
70 North Main Street
Wilkes Barre, Pa 18711**

Customer Service Phone: **1-800-822-8753**

Website: www.bcnepa.com

Prescription Drugs: **1-877-603-8399**

The Subscriber Number shown on my Identification Card is:

The Group Number shown on my Identification Card is:

The "Effective Date" when my coverage begins is:

TABLE OF CONTENTS

Responsibilities for Plan Administration	5
Coordination of Benefits	8
Subrogation	10
Benefit Summary	14
Definitions	17
Primary Care Physician Covered Services	23
Specialist Physician Covered Services	26
Inpatient Hospital and Skilled Nursing Covered Services	27
Emergency Care	30
Out of Area Covered Services for Unexpected Conditions	31
Prescription Drugs	32
Self Referred Covered Services	33
Exclusions	35
Participant Eligibility	37

Plan Administrator

The University of Scranton
Linden and Monroe Ave.
Scranton, PA 18510-4679
Phone: (570) 941-7767

Employer Identification Number

24-0795495

Plan Number

501

Participants

The benefits in this summary apply to active employees of The University of Scranton.

Contributions

The premiums for your benefits under the plan are paid by the employer

Plan Effective Date

2-1-99

Named Fiduciary

The University of Scranton
Human Resources Department
Linden and Monroe Ave.
Scranton, PA 18510-4679
Phone: (570) 941-7767

Plan Records

The records for the plan are reported on a calendar year basis beginning each January 1 and ending December 31.

This booklet describes, in general, the main features of the Plan. Complete terms and conditions are set forth in the Agreement between Blue Cross, Blue Shield and your employer. The Plan is self-funded health plan and the administration is provided through Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield, 70 North Main Street, Wilkes-Barre, PA 18711

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

This booklet has been prepared to meet the summary Plan description requirements of the Employee Retirement Income Security Act of 1974. The benefits provided under the Plan are subject to the terms and conditions of the group insurance contract issued by Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield, 70 North Main Street, Wilkes-Barre, PA 18711.

Name of Plan

The University of Scranton.

Employer and Plan Sponsor

The University of Scranton
Linden and Monroe Ave.
Scranton, PA 18510-4679
Phone: (570) 941-7767

Plan/Type Administration

The program described in this booklet is an employee welfare plan providing Hospital, Medical-Surgical and Major Medical benefits administered by Blue Cross of Northeastern Pennsylvania and Pennsylvania Blue Shield.

The benefits provided under this Plan and all statements in this booklet are subject to the terms and conditions of the Agreement between Blue Cross, Blue Shield and The University of Scranton.

Responsibilities for Plan Administration

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

Duties Of The Plan Administrator

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

Plan Administrator Compensation

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

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

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

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

The Named Fiduciary

A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

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

Claims Administrator Is Not A Fiduciary

The cost of the Plan is funded as follows:

For Employee Coverage: funding is derived solely from the funds of the Employer.

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

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

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

Effective Date

Newly hired and rehired full-time employees and their eligible dependents will be eligible for the benefits described in this summary plan description on the first of the date of hire.

Persons who become eligible dependents of an enrolled employee after the effective date of the employee’s enrollment will be eligible for these benefits upon notification from employee of such additional dependents.

Each eligible employee must complete an application form.

Statement of ERISA Rights

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

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

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suite in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

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

Agent For Service of
Legal Process on the Plan

The University of Scranton
Linden and Monroe Ave.
Scranton, PA 18510-4679
Phone: (570) 941-7767

Loss of Benefits

Upon 60 days written notice, the Plan Administrator may terminate this contract or, subject to Blue Cross and Blue Shield approval, may modify, amend or change the benefit provisions, terms, and conditions of the contract. No consent of any participant, or any other person referred to on the contract, shall be required to terminate, modify, amend or change the contract.

Plans maintained as a result of collective bargaining agreements are, of course, subject to change negotiated in the collective bargaining process.

If you are laid off, resign, or retire, all health care benefits described herein for you and for your dependents will cease at the end of the month in which the event occurs.

If the coverage described in this booklet is terminated because it is being replaced by another carrier, all benefits will cease on the date when such other coverage becomes effective.

Portability

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you terminate employment and obtain health insurance coverage elsewhere which has a pre-existing condition exclusion, you may be entitled to receive credit toward the exclusionary period, provided you have not had a break in coverage of more than 63 days. At the time you terminate coverage with us, BCNEPA will provide you with a certificate of coverage showing the period of time during which you were covered under this program. This new insurer will reduce its exclusionary period, if any, in accordance with that information.

Coordination of Benefits

In order to avoid duplication of payment for covered services received by the participant,

payment for benefits under this Plan will be coordinated with other group health Plans.

1. In the event a participant is covered under a Benefit program other than this Plan, which does not contain a provision coordinating its benefits with those of this Plan, such other Plan will be primary Plan and as such shall determine its benefits before benefits are determined under this Plan. Benefits payable under another Plan include the benefits that would be payable, whether or not claim is made therefore.

Such other Plan may include any company-sponsored Plan, including any group Blue Cross/Blue Shield Plan, franchise arrangements, or any company-sponsored Plan to which any employer contributes or makes payroll deductions. Such other Plan will not include blanket student accident coverage.

2. When a participant is covered under another Plan which contains a provision coordinating its benefit with those of this Plan, the following rules will establish order of determining liability of this or any other Plan:
 - a. The Plan covering the patient as a contract Holder is the primary Plan, which shall determine its benefits before benefits are determined under any other Plan.
 - b. Except for situations where the parents of a child are separated or divorced:
 - i. The Plan of the parent whose date of birth (month/day) falls earlier in the calendar year is the primary Plan. If both parents have the same birthday, the Plan which covered the parent longer will be the primary Plan; or
 - ii. If this Plan is coordinating with a Plan which uses the rule based on the gender of the parent, the Plan of the male parent is the primary Plan.

- c. In those situations where the parents of the child are separated or divorced;
 - i. The Plan covering the child as a dependent of the parent with custody will be the primary Plan;
 - ii. If the parent with custody has remarried, the Plan which covers the child as a dependent of the step-parent with custody will be the primary Plan;
 - iii. Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary Plan, as long as the Plan of the parent has actual knowledge of the court decree; or
 - iv. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph 2.b.
- 3. Where the determination cannot be made in Accordance with the above, the Plan which has covered the participant for the longer period of time will be considered the primary Plan, except:
 - a. The Plan which covers the participant as an active employee (or a dependent of such a person) is the primary Plan over a Plan that covers a participant as laid-off or retired employee (or dependent of such a person); or
 - b. If either Plan does not have a provision regarding laid-off or retired employees and as a result, the benefits of each Plan are determined after the other, then the provisions of a 3.a. above shall not apply.
- 4. Services provided under any governmental Program for which any periodic payment of rate is made by or for the participant shall always be the primary Plan, except where prohibited by law.
- 5. Individual Non-Group Health Plans of any kind will not be coordinated when the participant pays the entire cost.
- 6. When this Plan is determined to be the Primary Plan, benefits will be paid without regard to coverage under any other Plan and there are remaining covered services, this Plan will pay its regular benefit up to the amount of such remaining eligible covered services.
- 7. Facility of Payment – Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, Blue Cross and Blue Shield will have the right, at their sole discretion, to pay to any organization making such other payments any amounts they determine to be warranted in order to satisfy the intent of this provision and amounts so paid will be considered benefits paid under this Plan and Blue Cross and Blue Shield will be fully discharged from liability.
- 8. Right of Recovery – Whenever payments have been made by Blue Cross and Blue Shield in excess of the maximum amount of payment necessary to satisfy the intent of this provision, irrespective of to whom paid, Blue Cross and Blue Shield will have the right to recover such payments to the extent of such excess from among one or more of the following, as Blue Cross and Blue Shield will determine:
 - a. Any persons to or for or with respect to whom such payments were made (including the participants covered under this Plan);

- b. Any insurance companies; and
- c. Any organization.

Blue Cross and Blue Shield may use such reasonable efforts as deemed suitable to determine the existence of other Plans but will be under no obligation to do so. Blue Cross and Blue Shield shall not be required to determine the existence of any contract or amount of benefits under any Plan except this Plan and the payment of benefits under this Plan shall be affected by the benefits under any and all other Plans only to the extent that Blue Cross and Blue Shield are furnished with information relative to such other Plan by the group or participant or any other organization or person.

When the benefits are reduced under the primary Plan because a participant does not comply with the Plan provisions, the amount of such reduction will not be considered covered services. Examples of such provisions are those related to second surgical opinions, prior certification of admissions and services and preferred provider arrangements.

This Coordination of Benefits provision does not apply to individual, non-group or group conversion policies.

Subrogation

A. Plan Responsibilities

Plan represents and warrants that the Summary Plan Description confers on the Plan rights of subrogation and third part recovery. Plan delegates or assigns these subrogation rights and third party recovery rights to Blue Cross of Northeastern Pennsylvania as the Plans agent for purposes of subrogation.

B. BCNEPA's Subrogation Duties

Blue Cross of Northeastern Pennsylvania shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. Blue Cross of Northeastern

Pennsylvania shall be subrogated, and succeed to the rights of recovery of a participant for expenses incurred against any person or organization except insurers or policies of health insurance issued to and in the name of participant. In those instances where the subrogation recovery efforts of the participant's attorney should, in the opinion of Blue Cross of Northeastern Pennsylvania, be compensated, the Plan delegates to Blue Cross of Northeastern Pennsylvania full authority to act on behalf of the Plan to negotiate reasonable attorney fees not to exceed thirty-three and one-third percent (33 1/3%) for personal injury cases, up to forty percent (40%) for medical malpractice cases and twenty percent (20%) for worker's compensation cases. Any determination by Blue Cross of Northeastern Pennsylvania will respect to attorney fees shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review. Blue Cross of Northeastern Pennsylvania shall provide the participant's attorney with updated lien amounts, as requested, and shall work with the participant's attorney to recover 100% of the Covered Services paid (unless such amount is compromised as set forth in Section C). Blue Cross of Northeastern Pennsylvania shall credit the plan with the amount recovered, minus, as applicable, a prorata share of the costs and the participant's attorney fees.

C. Authority to compromise Liens

In those instances where a plan's subrogation lien should, in the opinion of Blue Cross of Northeastern Pennsylvania, be compromised, the plan delegates to Blue Cross of Northeastern Pennsylvania full authority to act on behalf of the plan to compromise the lien. Any determination by Blue Cross of Northeastern Pennsylvania with respect to subrogation liens shall be final and conclusive, unless overturned under a limited arbitrary and capricious standard of review.

D. Participant's Duties

The participant shall pay to Blue Cross of Northeastern Pennsylvania all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided and paid under the plan less any attorney's fees and expenses. The participant shall take such action, furnish such information and assistance, and execute such papers as Blue Cross of Northeastern Pennsylvania may require to facilitate enforcement of its rights and shall take no action prejudicing the rights and interest of Blue Cross of Northeastern Pennsylvania.

E. Prohibited by Law

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Employers with twenty (20) or more employees (as defined under COBRA to mean full or part-time and whether or not enrolled for coverage under this Contract) are subject to COBRA regulations. Employers with less than twenty (20) employees are not subject to COBRA regulations and cannot make available continuation coverage under this Contract after the Subscriber ceases to be an Eligible Person.

Upon timely notice from the Group, the Plan will make available continuation coverage, as required by COBRA, for all Employees and their Dependents determined to be qualified beneficiaries, as defined in Section 162 (k) (7) (B) of the Internal Revenue Code as amended from time to time, and Section 607 (3) of the Employee Retirement Income Security Act (ERISA), as amended from time to time. The Group shall retain full responsibility for notifying Employees of their rights to continuation coverage and administering the exercise of continuation rights, as required by COBRA. The Plan shall have no obligation to ensure that any termination instructions received from the Group comply with the requirements of COBRA. For purposes of

COBRA, the Plan is not the administrator as defined under ERISA.

Each Employee has a right to continue coverage if:

1. Employment with the Group ends for a reason other than gross misconduct; or
2. Work hours are reduced.

Each Dependent has a right to continue coverage if:

1. The Employee's employment with the Group ends for a reason other than gross misconduct;
2. The Employee's work hours are reduced;
3. The Employee dies;
4. In the case of an Employee's spouse, when such spouse ceases to be an Eligible Dependent as a result of divorce or legal separation;
5. The Employee becomes entitled to Medicare; or
6. In the case of a Dependent child, when such child no longer satisfies the eligibility requirements for coverage as a Dependent under this Contract.

Under the COBRA law, the Employee or an Eligible Dependent has the responsibility to inform the administrator (as defined under ERISA) of a divorce, legal separation, or a child losing dependent status under this Contract within sixty (60) days of the date of the later of the event or the date on which coverage would end under this Contract because of the event. The Group has the responsibility to notify the administrator of the Employee's death, termination of employment, reduction in hours or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if the Group commences a bankruptcy proceeding.

When the administrator is notified that one of these events has happened, the administrator will in turn notify the qualified beneficiary within

fourteen (14) days of the notification that he/she has the right to choose continuation coverage. The qualified beneficiary has at least (60) days from such notification to inform the administrator of his or her decision to elect continued coverage. The qualified beneficiary will then have forty-five (45) days after notifying the administrator of his or her decision to pay the retroactive premium.

In the case of the Employee's termination of employment or reduction in work hours, the coverage may be continued for up to eighteen (18) months. The eighteen (18) months may also be extended to twenty-nine (29) months if an individual is determined to be disabled (for Social Security disability purposes) and the administrator is notified of the determination within sixty (60) days. The affected individual must also notify the administrator within sixty (60) days of any final determination that the individual is no longer disabled. With respect to all other qualifying events, coverage may be continued for up to thirty-six (36) months. Furthermore, in no event will continuation coverage last beyond thirty-six months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The end of the maximum coverage period is measured from the date of the qualifying event does not result in a loss of coverage under this Contract until some later date.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The Group ceases to provide group health insurance to any Employee;
2. The qualified beneficiary fails to make timely payments of any premium required;
3. The qualified beneficiary is covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that the qualified beneficiary may have;
4. The qualified beneficiary is entitled to benefits under Medicare; or

5. The qualified beneficiary extended coverage for up to twenty-nine (29) months due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.

Continuation During Family and Medical Leave

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

Leave taken under the Family Medical Leave Act shall be covered under this plan on the same conditions as previously provided, as though the Employee has been continuously employed up to the 12-week leave period.

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

Conversion

If the subscriber ceases to be a participant for this program because of layoff, disability, leave of absence or termination of employment, arrangements may be made to continue both Blue Cross and Blue Shield under the direct payment type of participant Agreements. However, if a participant becomes one of a group having benefits available under a Health insurance Program other than Blue Cross, he or she is not entitled to this conversion privilege.

If the participant dies, the surviving spouse and child may continue coverage under the direct payment type of subscriber Agreements.

Children who reach the maximum age limit specified in the program also have the privilege of converting to the direct payment type of subscriber Agreements.

Misrepresentations

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

Covered Services

	<u>PCP Referred</u>	<u>Self Referred</u>
Deductible	None	\$200/\$600
Annual Out-of-Pocket Maximum	None	\$1,000/\$3,000
Lifetime Maximum	Unlimited	\$1,000,000
Precertification Penalty	None	\$300 penalty for late Precertification NO PRECERTIFICATION ON FILE: NO PAYMENT
Coinsurance	100% coverage	80% coverage
Choice of Hospital	Hospital associated With FPH	Accredited facilities nationwide
Inpatient Hospital Services	100% Precertification Required	80% \$300 penalty if late Precertification
Outpatient Hospital Surgery	100% Precertification Required	80% \$300 penalty if late Precertification
Anesthesia	100%	80%
Surgeon/Assistant Surgeon	100%	80%
Pre-Admission Testing	100%	80%
PHYSICIAN SERVICES		
Choice of Physician	Physicians participating With First Priority Health	Any licensed accredited physician
PCP/Specialist Office Visits	\$15 PCP copay \$25 Specialist copay	80%
Pediatric Immunizations	\$15 copay if office visit	80% Not subject to deductible
Routine GYN Exams	\$25 copay	80%
MATERNITY SERVICES		
Maternity Care	\$25 copay for first visit; Then 100%	80%
Invitro & In vivo Fertilization		Not covered
Pediatric Visits (In Hospital)	100%	80%
Sterilization (Vasectomy/Tubal)		Not covered
TESTS		
Allergy Tests & Treatments	\$15 PCP copay \$25 Specialist copay	80%

	<u>PCP Referred</u>	<u>Self Referred</u>
Lab Tests	100%	80%
Mammography	100%	80%
X-rays	100%	80%
EMERGENCY SERVICES		
Emergency Medical/Accident	\$35 copay; waived if admitted	
THERAPY SERVICES		
Dialysis, Chemotherapy, Radiation Therapy	100%	80%
Cardiac Rehabilitation	100%	80%
	36 sessions/12 week period Precertification required	
Occupational Therapy	100%	80%
	45 visits per year Precertification required	
Physical Therapy	100%	80%
	45 visits per year Precertification required	
Respiration Therapy	100%	80%
	Precertification required	
Cognitive Therapy	100%	80%
	45 visits per year Precertification required	
Speech Therapy	100%	80%
	45 visits per year Precertification required	
OTHER SERVICES		
Durable Medical Equipment Orthotics & Prosthetics	100%	80%
	\$2,500 annual maximum Precertification required	
Home Health Care	100%	80%
	Precertification required	\$300 penalty if late Precertification
Hospice	100%	80%
	Precertification required	180 day lifetime maximum \$300 penalty if late Precertification
Ambulance	100%	80%
Oral Surgery	100%	80%
	Precertification required	\$300 penalty if late Precertification
Impacted Wisdom Teeth		Not covered
Spinal Manipulation		Not covered
Skilled Nursing Facility	100%	80% (90 days per year) Precertification required

	<u>PCP Referred</u>	<u>Self Referred</u>
Transplants	100% PAC required	No self-referred coverage
PHARMACY		
Prescription Drugs	\$10 copay at community Pharmacy (90 day supply) \$20 mail order copay (for 90 day supply) Mandatory generic	No self-coverage (emergency Rx covered under base HMO policy)
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES		
Inpatient Mental Health	100% 35 days/calendar year, precertification required	80%
Outpatient Mental Health	\$10 copay 20 visits/year, precertification required	50%
Inpatient Substance Abuse	100% first course 2 nd course reduced to 50% 90 day lifetime maximum, precertification required	80% first course 2 nd course reduced to 50%
Outpatient Substance Abuse	100% 30 visits/calendar year Additional 30 or equivalent partial may be exchanged on a 2:1 basis for up to 15 non-hospital residential days, precertification required	80%
Detoxification	100% 7 days per admission, 4 admissions per lifetime	80%

Section I. Definitions

- A. The following words and phrases when used herein shall have, unless the context clearly indicates otherwise, the meaning given to them below:
1. **ALCOHOL 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 this summary, “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.).
 2. **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 Health’s Care Management Department, in cooperation with the Primary Care Physician, organizes and coordinates managed care through multidisciplinary resources.
 3. **CALENDAR YEAR** – A one (1) year period which begins on January 1 and ends on December 31.
 4. **COINSURANCE** – The percentage of the Provider’s Reasonable Charge or the Reasonable Equitable Fee for a Self-Referred Covered Services that is the responsibility of the Participant after the Deductible is satisfied, as set forth in the “Covered Services” section.
 5. **COPAYMENT** – The amount a Participant must pay directly to Providers of health care in connection with Covered Services set forth in the “Covered Services” section.
 6. **COSMETIC PROCEDURES** – Medical or surgical procedures which are intended to improve the appearance of any portion of the body and from which no improvement in physiologic function can be expected.
 7. **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 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 should not be based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.
 8. **DEDUCTIBLE** – The portion of charges for Self-Referred Covered Services that First Priority Health considers to be the Provider’s Reasonable Charge (PRC) or the Reasonable Equitable Fee (REF), that must be incurred by a Participant before First Priority Health will assume any liability for all or part of the remaining Self-Referred Covered Services, as set forth in the “Self-Referred Covered Services” section.
 9. **DEPENDENT** – Any person in a Subscriber’s family who meets all the eligibility requirements as specified by the Plan and has enrolled for coverage.
 10. **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 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.

11. DRUG FORMULARY – A listing of drugs which are preferred for use by First Priority Health, which is subject to periodic review and modification by a committee of Physicians and Pharmacists.

- 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.

12. 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.

13. EMERGENCY SERVICES – Professional health care services for a condition which requires immediate medical attention to preserve life or stabilize health; such services are available on an Inpatient or Outpatient basis, twenty-four (24) hours per day, seven (7) days per week.

14. FACILITY OTHER PROVIDER – An institution or entity other than a Hospital which is licensed, where required, to render covered services. Facility Other Providers include:

- * Ambulatory Surgical Facility
- * Durable Medical Equipment Supplier
- * Freestanding Dialysis Facility
- * Freestanding Outpatient Facility
- * Home Health Care Agency
- * Home Infusion Therapy Agency
- * Hospice
- * Inpatient Non-Hospital Residential Facility
- * Orthotics and Prosthetics Supplier
- * Outpatient Psychiatric Facility
- * Pharmacy
- * Psychiatric Hospital
- * Rehabilitation Hospital
- * Skilled Nursing Facility
- * Substance Abuse Treatment Facility

15. FULL-TIME STUDENT – A Participant who is attending a recognized college or university, trade or secondary school as certified by the Plan Administrator.

16. GENERIC EQUIVALENT DRUG - Any drug Product 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.

17. GROUP THERAPY – Counseling of two (2) or more individuals at one (1) time to resolve an identified problem. This type of therapy is lead by a Participating Provider.
18. HOME HEALTH CARE AGENCY - A Facility Other Provider which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or First Priority Health which:
- provides skilled Outpatient services on a visiting basis in the Participant’s home; and
 - is responsible for supervising the delivery of such services under a plan authorized by the Primary Care Physician.
19. HOME INFUSION THERAPY AGENCY – A Facility Other Provider that provides hi-tech services designed to coordinate the effective provision of Physician directed nursing, Pharmacy and related services necessary to conduct a parental/enteral regime safely and effectively in the patient’s home.
20. HOSPICE – a Facility Other Provider, approved by First Priority Health, which is primarily engaged in providing palliative care to terminally ill individuals.
21. 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 or by First Priority Health, and which:
- is a duly licensed institution;
 - 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;
- has organized departments of medicine and/or major surgery;
 - provides twenty-four (24) hour nursing service by or under the supervision of registered nurses; and
 - is not, other than incidentally, a:
 - * Skilled Nursing Facility
 - * Nursing Home
 - * Custodial Care Home
 - * Health Resort
 - * Spa or Sanitarium
 - * place for rest
 - * place for the aged
 - * place for the treatment of mental illness
 - * place for the provision of Hospice care, or
 - * personal care home
22. INPATIENT – A Participant who is treated as a registered overnight bed patient in a Hospital or Facility Other Provider.
23. 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.
24. INPATIENT NON-HOSPITAL RESIDENTIAL FACILITY – A Facility Other Provider licensed by the Department of Health to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care.

25. LIFETIME COVERED SERVICES MAXIMUM – The maximum dollar amount of Cover Services paid by First Priority Health for Self-Referred Covered Services provided under the Agreement during the lifetime of any Participant, as set forth in the “Self-Referred Covered Services” section.
26. 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.
27. MAINTENANCE PRESCRIPTION DRUG – Any Prescription Drug, not specifically designated, 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 from a Participating Mail Order Pharmacy.
28. MEDICAL SERVICES - Professional services rendered by a Physician or Professional Other Provider.
29. MEDICARE – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
30. ORTHOTICS -- 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.
31. OUT-OF-AREA CARE FOR AN UNEXPECTED CONDITION – Outpatient medical care that is required, while the Participant is out of the First Priority Health service area, for an unexpected condition that is not life threatening and cannot reasonably be postponed until the Participant returns to the First Priority Health service area.
32. OUTPATIENT – Services or supplies received by a Participant while not Inpatient.
33. OUT-OF-POCKET COINSURANCE MAXIMUM – The maximum dollar amount of Coinsurance which must be incurred by a Participant for Self-Referred Covered Services in a Calendar Year, as set forth in the “Self-Referred Covered Services” section.
34. PARTIAL HOSPITALIZATION – The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or facility other provider licensed as a mental health or Alcohol and/or Drug Abuse treatment program by the Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require Inpatient care.
35. 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.
36. 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.

37. **PHYSICIAN** – A person who is a doctor of medicine (M.D.) or a doctor of Osteopathy (D.O.), licensed and legally entitled to practice medicine in all its branches.
38. **PRE-CERTIFICATION** – The process of providing initial Prior Authorization to a Provider via telephone review by the Provider and First Priority Health with regard to the Medical Necessity of a service, supply or procedure prior to the date of service. Upon initial approval by First Priority Health, a Pre-certification number is issued to the Provider. When Self-Referred Covered Services are being used, this process of determining Medical Necessity is between the Participant and First Priority Health and the Pre-Certification number is issued to the Participant.
39. **PRESCRIPTION DRUGS** – Any medication which by federal/or state law may not be dispensed without a prescription order issued by a licensed practitioner authorized by law to prescribe such drugs.
40. **PRIOR AUTHORIZATION** – The process whereby Participants are given initial determination of approval to receive Covered Services from a Provider other than the Primary Care Physician. Section II of this summary identifies when Prior Authorization is required from the Primary Care Physician or from both the Primary Care Physician and First Priority Health. Prior Authorization is issued as either a Written Referral or Pre-certification, in accordance with First Priority Health's policies and procedures.
41. **PRIVATE DUTY NURSING** – Total patient care provided by a registered

nurse or licensed practical nurse on an individual basis.

42. **PROFESSIONAL OTHER PROVIDER** – An individual or practitioner other than a Physician who is licensed where required to render Covered Services. Professional Other Providers include, but are not limited to:
- * Certified Addiction Counselor
 - * Nurse Practitioner
 - * Chiropractor
 - * Occupational Therapist
 - * Clinical Psychologist
 - * Optometrist
 - * Clinical Nurse Specialist
 - * Physical Therapist
 - * Dentist
 - * Physician Assistant
 - * Independent Clinical Laboratory
 - * Podiatrist
 - * Registered Nurse
 - * Licensed Practical Nurse
 - * Social Worker
 - * Nurse Midwife
 - * Speech Therapist
43. **PROSTETICS** – 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.
44. **PROVIDER'S REASONABLE CHARGE (PRC)** – A dollar amount that First Priority Health determines is reasonable for Self-Referred Covered Services provided to a Participant from a Hospital or Facility Other Provider,

as set forth in the “Self-Referred Covered Services”.

45. REASONABLE EQUITABLE FEE (REF) – A dollar amount that First Priority Health determined is reasonable for Self-Referred Covered Services provided to a Participant by a Physician or a Professional Other Provider, as set forth in the “Self-Referred Covered Services”.
46. RECONSTRUCTIVE PROCEDURES – Procedures performed on a structure of the body to improve and/or restore bodily function (i.e. congenital or developmental anomalies) or to correct deformity resulting from disease, trauma or a previous therapeutic process.
47. REGIONAL REFERRAL CENTER – First Priority Health’s dedicated unit that provides eligibility verification, triage, referral and utilization management for mental health-chemical recovery services.
48. SELF-REFERRAL FORM – A form that Participants must complete, sign and return to First Priority Health when filing a claim for Self-Referred Covered Services.
49. SELF-REFERRED COVERED SERVICES – The provision of Self-Referred Covered Services to Participants at a reduced level of payment as set forth in the “Self Referred Covered Services”.
50. SKILLED INPATIENT CARE – Covered Services that are authorized by the Primary Care Physician as rehabilitative services (not maintenance or Custodial Care), performed in a Skilled Nursing Facility on a daily basis and which can only be performed by, or under the supervision of, licensed professional personnel or professional therapists, such as physical therapists, occupational therapists, and speech pathologists or audiologists. Services which are needed only occasionally, such as once or twice a week, or rehabilitation services which are no longer improving the Participant’s condition and may be carried out by someone other than the skilled therapist, are not considered Skilled Inpatient Care.
51. 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 and drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested, or is otherwise approved by First Priority Health.
52. 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.
53. 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 this summary.
 - a. RADIATION THERAPY – The treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
 - b. CHEMOTHERAPY – The treatment of malignant disease by chemical or biological antineoplastic agents.
 - 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. 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.
- e. RESPIRATORY THERAPY – The introduction of dry or moist gases into the lungs for treatment purposes.
- f. 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.
- g. SPEECH THERAPY – The treatment for the correction of speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.
- h. CONGNITIVE THERAPY – The treatment designed to correct the disorder involving disruption in such mental activities as conscious thought, problem solving, judgment and comprehension related to coping.

54. TRANSITIONAL LIVING FACILITY – A facility that renders Long-Term Residential Care. This type of facility can be licensed, when appropriate, by the Department of Health. However, a facility providing Long-Term Residential Care is not to be considered an Inpatient Non-

Hospital Residential Facility rendering inpatient Non-Hospital Residential Care. Specific Transitional Living Facilities include half-way houses, group homes or supervised apartment settings.

55. WRITTEN REFERRAL – Prior initial Authorization documented in writing, on a form provided by First Priority Health, authorizing a Participant to receive Covered Services from a Provider other than the Primary Care Physician.

Section II. Covered Services

A. PRIMARY CARE PHYSICIAN COVERED SERVICES

Except in an emergency as described in Section II.G. of this summary, the following services will be provided to Participants when Medically Necessary and at or through the Participant’s Primary Care Physician’s office of record, or at other Participating Providers upon initial Prior Authorization by the Participant’s Primary Care Physician. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon initial Prior Authorization by the Participant’s Primary Care Physician and First Priority Health’s Medical Director. Covered Services from the Primary Care Physician include:

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by First Priority Health, in conjunction with the Primary Care Physician, the Participant and, as appropriate, the Specialist Physician. When possible, the Specialist Physician must be a Participating Professional Provider. Covered Services from the Primary Care Physician include:

1. Office visits during office hours and during non-office hours when Medically Necessary. Participant is responsible for a Copayment for each such visit in the amount shown on the “Covered Services when coordinated through your Primary Care Physician”.
2. Home visits by the Participant’s Participating Primary Care Physician, if the Participant’s Primary Care Physician deems it Medically Necessary. Participant is responsible for a Copayment for each home visit in the amount shown on the “Covered Services when coordinated through your Primary Care Physician”.
3. Well child care from birth.
4. Childhood immunizations. Covered Services are provided for these immunizations, including the 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. Covered Services are limited to Participants until age twenty-one (21); however, there is no age restriction for Dependent Children. Covered Services are exempt from any Deductibles of dollar limits.
5. Adult immunizations; but not solely for the purpose of travel or work.
6. Routine physical examinations, once per Calendar Year and additional examinations when Medically Necessary.
7. Routine allergy injections.
8. Routine annual gynecological examinations including a pelvic examination, clinical breast examination and one (1) routine Papanicolaou smear for female Participants per Calendar Year. Participants can utilize their Primary Care Physician for this service or they can choose a participating gynecologist. If the plan participant requires gynecological services, they are permitted to select a specialist participating within the plan to obtain maternity or medically necessary gynecological care. This includes medically necessary and appropriate follow-up care and written referrals for diagnostic testing related to maternity and gynecological care, without prior approval from their Primary Care Physician. Such health care services should be within the scope of practice of the selected participating professional provider, who is responsible for keeping your Primary Care Physician informed of all health care services provided. This Covered Service is exempt from any Deductibles or dollar limits.
9. Laboratory and x-ray services, EKGs and other diagnostic services.
10. Casts.
11. Emergency coverage arrangements through the Participant’s Primary Care Physician’s office which are available twenty-four (24) hours a day, seven (7) days a week.
12. Follow-up care after Emergency Services.
13. Obstetrical services. A female Participant may select a Participating Professional Provider for maternity and gynecological services, including Medical Necessary follow up care and Written Referrals for diagnostic testing relating to maternity and gynecological care, without prior approval from the Participant’s Primary Care Physician. Such health care services shall be within the scope

of practice of the selected Participating Professional Provider, who is responsible for keeping the Participant's Primary Care Physician informed of all health care services provided.

14. Therapeutic drugs, medications and injectables, only when deemed a critical part of the therapeutic Covered Service being rendered by the Primary Care Physician during an office visit, and when Medically Necessary. Coverage is limited to the amount of therapeutic drug, medication or injectable administered during the office visit. Coverage does not include infertility injectables, when used for the purpose of ovulation, and contraceptives, when used for the purpose of birth control. First Priority Health has the right to require authorization for certain injectables in order to determine medical necessity.

Copayment – If a Participant has an office visit with their Primary Care Physician, the Participant is responsible for the appropriate Copayment in the amount shown for Primary Care Physician Office Visits on the “Covered Services when coordinated through your Primary Care Physician”.

Participants may utilize their Primary Care Physician for Obstetrical Services. Participants are responsible for the appropriate Copayment in the amount shown for Obstetrical Services – Primary Care Physician Office Visit on the “Covered Services when coordinated through your Primary Care Physician”. A Copayment is charged for the first obstetrical office visit. No charge is made for second and subsequent obstetrical office visits.

B. OUTPATIENT COVERED SERVICES

Except in an emergency as described in Section II.G. of this Summary, the following services will be provided to Participants when Medically Necessary and at or through the Participant's Primary Care Physician's office of record, or at other Participating Providers upon Prior Authorization by the Participant's Primary Care Physician. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon initial Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Medical Director. Outpatient services include:

1. Ambulance service:
 - a. in an emergency, but subject to the notification requirements set forth in Section II.G. of this summary; or
 - b. in a non-emergency upon Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department.
2. Ambulatory surgery (i.e., surgery performed in an acute-care Hospital's short procedure unit or freestanding surgical facility), upon initial Prior authorization by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department.
3. Laboratory and x-ray services, EKGs and other diagnostic services.
4. Outpatient surgery (i.e., surgery performed in a Physician's office or in an acute care Hospital's Outpatient department).
5. Medical social services and other health services to include:
 - a. pre- and post-hospital planning;

- b. referral to (but not payment for) community health and social welfare agency services;
 - c. referral to (but not payment for) related family counseling services except as specified in Section II.E.1;
 - d. referral to and payment for services of appropriate family planning agencies as necessary; and
 - e. referral to appropriate specialties for payment for fertility services, except injectable and infertility related supplies.
6. Home health and Hospice services, upon Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department.
 7. Mammography screenings. One (1) mammography screening per Calendar Year is covered for all Participants age forty (40) and over whether or not directed toward a definite condition of disease or injury. Diagnostic mammographies with Prior Authorization by a Primary Care Physician are covered for all Participants.
 8. Dialysis Treatment.
 9. Oxygen and the initial equipment necessary to utilize oxygen, upon Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department, when Medically Necessary. Replacement of the initial oxygen equipment is not covered.
 10. Chemotherapy.
 11. Cardiac rehabilitation programs associated with Participating Providers. Participants may receive up to thirty-six (36) sessions, for a twelve (12) week period, upon Prior

Authorization from the Participant's Primary Care Physician and First Priority Health's Utilization Management Department.

12. Nutritional counseling at Participating Hospitals for Participants with diabetes mellitus or for pregnancy.
13. Radiation Therapy.
14. Infertility Testing, limited to laboratory, x-ray studies and surgical procedures necessary to confirm a diagnosis of infertility; and artificial insemination.
15. Diabetic supplies – First Priority Health Plus provides the following benefits related to diabetic supplies and outpatient self-management training and education:
 - * The cost of diabetic equipment and supplies, including blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.
 - * Outpatient self-management training and education, including information on proper diets, under the supervision of a licensed health care professional with expertise in diabetes.
 - * Coverage for outpatient self-management training and education benefits, including information on proper diets, will be provided when performed in a hospital setting by a participating facility.

C. SPECIALIST PHYSICIAN COVERED SERVICES

Except in an emergency as described in Section II.G., covered services will be provided to a Participant by a Participating Specialist Physician or at a Participating Hospital Outpatient department if, Medically Necessary and upon Prior Authorization by

Participant's Primary Care Physician. Standing Referrals – If the Plan Participant meets our established criteria of having a life threatening, degenerative or disabling disease, they may receive upon request, a standing referral to a specialist with clinical expertise in treating the disease; or utilize the specialist to provide and coordinate all care needs related to their condition. The referral to or designation of a specialist will be for a treatment plan approved by First Priority Health. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary upon Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Medical Director. Specialist Physician services include, but are not limited to:

1. Allergy Care (except routine injections, which should be administered by Participant's Primary Care Physician).
2. Anesthesia.
3. Cardiology.
4. Endocrinology.
5. Gynecology and Obstetrics.
6. Internal Medicine.
7. Neurology.
8. Oncology.
9. Ophthalmology.
10. Oral Surgery for (a) any condition which is a result of trauma or disease, or (b) baby bottle syndrome prior to age four (4), once per lifetime.
11. Orthopedics.
12. Otolaryngology.
13. Pathology.
14. Pediatrics.
15. Radiology (except dental x-rays unless related to Covered Services).
16. Surgery.

17. Urology.

Copayment – If a Participant has an office visit with a Participating Specialist, the Participant is responsible for the appropriate Copayment in the amount shown for Specialist Physician Office Visits on the "Covered Services when coordinated through your Primary Care Physician".

Emergency – In an emergency as described in Section II.G., the services listed above will be covered without Prior Authorization, subject to all conditions and requirements set forth in Section II.G.

D. INPATIENT HOSPITAL & SKILLED NURSING FACILITY COVERED SERVICES

A Participant who is hospitalized by a Participating Physician, if Medically Necessary and upon Prior Authorization from Participant's Primary Care Physician and First Priority Health's Utilization Management Department, is entitled to the following Covered Services only at Participating Hospitals and Participating Skilled Nursing Facilities. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon Prior Authorization by the Participant's Primary Care Physician and First Priority Health's Medical Director. Covered Services in Skilled Nursing Facilities are limited to those which are Medically Necessary and which constitute Skilled Inpatient Care. Inpatient Hospital and Skilled Nursing Facility Covered Services include:

1. Semi-private room and board accommodations.
2. Private accommodations when Medically necessary and upon authorization by Participant's Primary Care Physician and First Priority Health's Medical Director. A Participant who occupies a private room

without such authorization shall be directly liable to the Participating Hospital or Participating Skilled Nursing Facility for the difference between payment by First Priority Health to the Participating Hospital or Participating Skilled Nursing Facility of the per-diem or other agreed-upon rate established between First Priority Health and the Participating Hospital or the Participating Skilled Nursing Facility and the private room rate.

3. General nursing care.
4. Use of intensive or special care facilities when Medically Necessary and Appropriate.
5. Diagnostic and therapeutic radiological procedures, except as specifically excluded in Section III.
6. Use of operating room and related facilities.
7. Drugs, medications and biologicals, when Medically Necessary.
8. Laboratory testing and services.
9. Pre- and post-operative care.
10. Special tests when Medically Necessary.
11. Therapy Services.
12. Oxygen.
13. Anesthesia and anesthesia services.
14. Unreplaced blood and blood components and the administration and processing of whole blood, blood plasma and blood derivatives.
15. Intravenous injections and solutions.
16. Dialysis Treatment.
17. Surgical, medical and obstetric services provided by a Participating Hospital.
18. Transplants that are Medically Necessary and not considered to be

Experimental of Investigative by First Priority Health for a recipient who is a Participant. Covered Services will be provided for the removal and transport of the organ from a living donor or cadaver only when the recipient is a First Priority Health Participant and only to the extent covered services are unavailable from any other source.

19. Chemotherapy.

Copayment – Participant is responsible for a Copayment in the amount shown for Inpatient Services on the “Covered Services when coordinated through your Primary Care Physician”.

Emergency – In an emergency as described in Section II.G. the services listed above will be covered without prior authorization subject to all the conditions and requirements set forth in Section II.G.

E. ALCOHOL AND/OR DRUG ABUSE TREATMENT COVERED SERVICES

Except in an emergency as described in Section II.G., the following Covered Services are provided only when Medically Necessary and when the First Priority Health Regional Referral Center (RRC) is notified and coordinates the Participant’s care before the Covered Services are rendered. Alcohol and/or Drug Abuse Covered Services include:

1. Outpatient – Participant is eligible for thirty (30) Outpatient full-service visits or equivalent partial visits per Calendar Year for treatment of Alcohol and/or Drug Abuse or dependency. (A visit is defined as one (1) hour of therapy.) Participant is additionally eligible for up to thirty (30) separate sessions of Outpatient visits or Partial Hospitalization days per Calendar Year. These additional thirty (30) sessions may be exchanged on a two-for-one basis for up to fifteen(15) Non-Hospital

Residential Care days, as described in Paragraph 3 below.

Treatment for Alcohol and/or Drug Abuse or dependency shall be provided according to an individualized treatment plan, subject to a lifetime limit of one-hundred-twenty (120) visits.

Covered Services involve diagnosis, Detoxification, medical treatment and medical referral services by the RRC for Alcohol and/or Drug Abuse. Covered Services also include:

1. Physician, psychologist, nurse certified addictions counselor and trained staff services;
2. Rehabilitation therapy and counseling;
3. Family counseling and intervention;
4. Psychiatric, psychological and medical laboratory tests;
5. Drugs, medicines, equipment use and supplies.

Participant out-of-area students may receive Outpatient Alcohol and/or Drug Abuse treatment out of the First Priority Health service area if:

- a. RRC coordinates the care, and
- b. the Participant maintains Full-Time Students status and attends classes.

If Inpatient treatment is required, the Participant must return to the First Priority Health service area to utilize coverage.

2. Inpatient Detoxification – Participant is eligible for Inpatient Detoxification Covered Services in either a Participating Hospital or an Inpatient Non-Hospital Residential Facility. This Inpatient Detoxification Covered Services is subject to a lifetime maximum of four (4) admissions per Participant. Reimbursement per

admission is limited to seven (7) days of treatment or an equivalent amount.

The following services shall be covered under Inpatient Detoxification treatment:

1. Lodging and dietary services;
 2. Physician, psychologist, nurse, certified addictions counselor and trained staff services.
 3. Diagnostic x-ray;
 4. Psychiatric, psychological and medical laboratory tests;
 5. Drugs, medicines, equipment use and supplies.
3. Inpatient Non-Hospital Residential Care – Participant is eligible for thirty (30) days per Calendar Year for Inpatient Non-Hospital Residential Care in an Inpatient Residential Facility, subject to a ninety (90) day lifetime limit. Inpatient Non-Hospital Residential Care Covered Services include:
 1. Lodging and dietary services;
 2. Physician, psychologist, nurse, certified addictions counselor and trained staff services;
 3. Rehabilitation therapy and counseling;
 4. Family counseling and intervention;
 5. Psychiatric, psychological and medical laboratory tests;
 6. Drugs, medicines, equipment use and supplies.

Copayment – Participant is responsible for the appropriate Copayment in the amount shown for Inpatient Alcohol and/or Drug Abuse treatment on the “Covered Services

when coordinated through your Primary Care Physician”.

F. MENTAL HEALTH CARE SERVICES

Except in an emergency as described in Section II.G., the following Covered Services will be provided to Participants only when Medically Necessary and when First Priority Health’s Regional Referral Center (RRC) is notified and coordinates the Participant’s care before the Covered Services are rendered.

1. Outpatient Mental Health Care Services:

Each Participant may receive twenty (20) visits each Calendar Year to a psychiatrist, clinical psychologist or psychiatric social worker in individual, group, family therapy or electroconvulsive therapy (ECT) sessions. A visit is one (1) hour of therapy or an ECT treatment.

Participant out-of-area students may receive Outpatient Mental Health treatment out of the First Priority Health service area if a) the Primary Care Physician and RRC coordinate the care, and b) the Participant maintains Full-Time Student status and attends classes. If the Participant has Inpatient mental health care coverage under the Agreement’s Mental Health Care Services Rider and Inpatient treatment is required, the Participant must return to the First Priority Health service area to utilize coverage under the Agreement.

Copayment – Participant is responsible for the appropriate Copayment for each visit in the amount shown for Outpatient Mental Health Visits on the “Covered Services when coordinated through your Primary Care Physician”.

G. EMERGENCY CARE

Emergency services are defined as any health care service provided to a plan participant after the sudden onset of a

medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing their health or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency services are available on an inpatient basis, twenty-four (24) hours per day, seven (7) days per week.

First Priority Health will reimburse the plan participant or their health care provider for the reasonable cost of emergency medical and hospital services (less appropriate Copayments) performed within or outside our service area by participating or non-participating providers without prior authorization. When processing a claim for emergency services, First Priority Health Plus will take into consideration the presenting symptoms as an emergency by a prudent lay person, and the services provided.

What to do in an emergency

If a situation arises where the plan participant feels emergency services are required, they should seek treatment immediately, because even the slightest delay may be harmful to their health. If the health care provider determines that emergency services are necessary, he or she will initiate necessary intervention to evaluate and, if necessary, stabilize the condition. The emergency care provider is not required to obtain prior authorization for emergency services from First Priority Health and the plan participant will only be responsible for the outpatient emergency

Room copayment identified in the “Covered Services” section of this summary.

If a plan participant is referred to the emergency room by their Primary Care Physician, they will only be responsible for the Primary Care Physician copayment.* If a plan participant is admitted to the hospital from the emergency room, the emergency room copayment is waived.

Conditions that require immediate medical treatment as emergencies include, but are not limited to:

- * Uncontrolled or excessive bleeding.
- * Acute pain requiring immediate attention, such as but not limited to, suspected heart attack or severe shortness of breath.
- * Serious burns.
- * Poisoning.
- * Convulsions.
- * Loss of consciousness.

Once the plan participant’s condition is stabilized, their care could be transferred from a non-participating provider to one within the network.

- The plan participant must pay the emergency room copayment to the hospital and obtain a paid-in-full receipt. Mail their receipt and ask their Primary Care Physician to mail their referral to the First Priority health Claims Department within five (5) days of the service. We'll reimburse the plan participant for the difference between their Primary Care Physician and emergency room copayment.
-

H. OUT-OF-AREA CARE COVERED SERVICES FOR AN UNEXPECTED CONDITION

For Non-Emergency Services outside the First Priority Health service area, Participants can receive Out-of-Area Care for an Unexpected Condition a) if they are traveling in the service area of an HMO that participates in the Away From Home Care Program and b) if they contact the HMO Blue USA Away From Home Care Coordinator for the coordination of care for the unexpected condition. Out-of-area non-Emergency Services which are not coordinated by an Away From Home Care Coordinator are not covered. Emergencies as described in Section II.G. need not be coordinated through this program.

I. REHABILITATION COVERED SERVICES

1. Speech Therapy-Speech Therapy Covered Services are available on a short-term basis. The Covered Service consists of treatment for forty-five (45) visits per Calendar Year, if the Participant’s Primary Care Physician certifies that the treatment will result in a significant improvement of the Participant’s condition within this time period and treatment is approved by First Priority Health’s Medical Director.
2. Physical Therapy – Physical Therapy Covered Services are available on a short-term basis. The Covered Services consists of treatment for forty-five (45) visits per Calendar Year, if the Participant’s Primary Care Physician certifies that the treatment will result in a significant improvement of the Participant’s condition within this time period and treatment is approved by First Priority Health’s Medical Director.
3. Occupational Therapy – Occupational Therapy Covered Services are available on a short-term basis. The covered services consists of treatment for forty-

five (45) visits per Calendar Year, if the Participant's Primary Care Physician certifies that the treatment will result in a significant improvement of the Participant's condition within this time period and treatment is approved by First Priority Health's Medical Director.

4. Cognitive Therapy – Cognitive Therapy Covered Services are available on a short-term basis. The Covered Services consists of treatment for forty-five (45) visits per Calendar Year, if the Participant's Primary Care Physician certifies that the treatment will result in a significant improvement of the Participant's condition within this time period and treatment is approved by First Priority Health's Medical Director.

J. DURABLE MEDICAL EQUIPMENT/ PROSTHETICS AND ORTHOTICS

Durable Medical Equipment, the initial provision of Prosthetics and the initial provision of Orthotics and the initial provision of hearing aids, as listed below, if Medically Necessary and approved by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department are covered. Instructions and appropriate services required for Participant to properly use the item such as attachment or insertion are also covered. Replacements are not covered, except as certified medically necessary for children.

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

- a. hospital beds and related equipment (bed rails, mattresses);
- b. equipment to increase mobility (standard wheelchairs);
- c. commodes (portable bedside commodes);

- d. oxygen and breathing apparatus (oxygen cylinders, positive and intermittent positive pressure breathing machines, suction machines);
- e. therapeutic equipment (infusion equipment, IV stands, and equipment);
- f. apnea monitors;
- g. glucose monitors (insulin dependent diabetics only) and;
- h. jobst stocking for burn diagnosis.

K. PRESCRIPTION DRUGS

1. Prescription drugs and medications are covered when prescribed by a licensed physician when Medically Necessary including, but not limited to, the following:

- insulin and insulin syringes for diabetics
- contraceptives when used for the purpose of birth control
- diabetic test agents

First Priority Health has the right to require prior authorization by First Priority Health for Prescription Drugs in order to determine medical necessity. A Participating Physician will advise the Participant when prior authorization is required prior to prescribing the drug. If the Participant utilizing a Non-Participating Physician, the First Priority Participating Pharmacy will advise the Participant when prior authorization is required prior to dispensing the drug. As soon as the authorization is obtained by the Participant, coverage for the drug will be available. Should a Participant elect not to obtain authorization from First Priority Health prior to receiving the Prescription Drug and is subsequently determined that the Prescription Drug was not Medically Necessary, no benefits will be provided by First Priority Health.

Each prescription is limited to a maximum 34-day supply, with up to five (5) refills

when authorized by a licensed physician, Prescriptions must be filled at a First Priority Health Participating Pharmacy. There is a \$10 generic pharmaceutical Copayment. Copayments are payable directly to the Participating Pharmacy for each prescription.

2. The Prescription drug mail order service is through Express Scripts Mail Services Inc. The mail order program provides significant cost savings when obtaining prescription medications.

Each Maintenance Prescription Drug is limited to a ninety day (90) supply based on the prescriber's directions for use and/or maximum daily dosages as indicated in the drug information literature and further subject to the supply limits authorized by the prescriber on the prescription order. 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.

The Maintenance Prescription Drug copay is \$20 generic pharmaceutical copayment.

L. SELF-REFERRED COVERED SERVICES

Participants may receive coverage at the reduced level of payment, as described in the "Self-Referred Covered Services", without initial prior authorization by the Participant's Primary Care Physician, only if the Participant follows the self-referral procedures as described in this Section;

The services are listed in Section II.L.1. or Section II.L.2; and First Priority Health determines that the services are Medically Necessary.

Before a Participant receives Self-Referred Covered Services, the Participant must complete and sign First Priority Health's

Self-Referral Form. Copies one (1) and two (2) of the Self-Referral Form should be sent by the Participant to First Priority Health within fourteen (14) calendar days, but no later than 180 calendar days from the date of service. Failure to submit the completed and signed Self-Referral Form to First Priority Health within 180 calendar days from the date of service, will result in the denial of payment. Copy three (3) is to be given to the Participant's self-referred Provider on the date of service. Copy four (4) is for the Participant's records. For Self-Referred Covered Services described in Section II.L.2., the Self-Referral Form applies to the number of days authorized by First Priority Health in one Pre-Certification. Subsequent visits and/or Pre-Certifications require additional Self-Referral Forms.

First Priority Health will inform the Participant's Primary Care Physician of the Self-Referred Covered Services received by the Participant, to assist the Participant's Primary Care Physician with the coordination of the Participant's future care.

1. Self-Referred Covered Services which require only the Self-Referral Form:
 - a. Primary Care Physician Covered Services, as outlined in Section II.A.
 - b. Outpatient laboratory and x-ray services, EKG's and other diagnostic services, as outlined in Section II.B.3.
 - c. Outpatient surgery, as outlined in Section II.B.4.
 - d. Medical social services and other health services, as outlined in Section II.B.5.
 - e. Mammography screenings, as outlined in Section II.B.7.

- f. Outpatient Dialysis, as outlined in Section II.B.8.
- g. Outpatient Chemotherapy, as outlined in Section II.B.10.
- h. Nutritional counseling, as outlined in Section II.B.12.
- i. Radiation Therapy, as outlined in Section II.B.13.
- j. Infertility Testing and artificial insemination, as outlined in Section II.B.14.
- k. Diabetes education services, as outlined in Section II.B.15.
- l. Specialist Physician Covered Services, as outlined in Section II.C.

2. Self-Referred Covered Services which require the Self-Referral Form and Pre-Certification:

Prior to receiving the Self-Referred Covered Services identified in this Section, in addition to completing the Self-Referral Form in accordance with this summary, Participant must receive initial Pre-Certification from First Priority Health's Utilization Management Department. To receive Pre-Certification, the Participant must phone First Priority Health's Utilization Management Department and provide evidence that the Self-Referred Covered Services are Medically Necessary. Although a Physician or Physician's office staff may phone First Priority Health for Pre-Certification on the Participant's behalf, it is the Participant's responsibility to ensure that initially Pre-Certification occurs prior to the date of service. When First Priority Health has determined that the Self-Referred Covered Services are Medically Necessary, First Priority Health will issue a Pre-Certification number to the Participant. It is the

Participant's responsibility to include First Priority Health's Pre-Certification number on the Self-Referral Form before the Participant submits the Self-Referral Form to First Priority Health and the Provider, in accordance with this summary.

Should the Participant fail to obtain initial Pre-Certification, when required, the Participant shall be liable for payment of a penalty equal to the first \$300 of charges for Covered Services. Such penalty shall not be applied toward the Participant's Out-of-Pocket Coinsurance Maximum.

The following are Self-Referred Covered Services which require the Self-Referral Form and initial Pre-Certification:

- a. Ambulatory surgery, as outlined in Section II.B.2.
- b. Home Health and Hospice services, as outlined in Section II.B.6.
- c. Outpatient oxygen, as outlined in Section II.B.9.
- d. Cardiac rehabilitation programs, as outlined in Section II.B.11.
- e. Inpatient Hospital and Skilled Nursing Facility Covered Services, as outlined in Section II.D., except for transplants as outlined in Section II.D.18.
- f. Alcohol and/or Drug Abuse Treatment Covered Services, as outlined in Section II.E.
- g. Mental Health Care Services, as outlined in Section
- h. Occupation Therapy, Physical Therapy, Speech Therapy and Cognitive Therapy, as outlined in Section II.I.

3. Hospitalization for transplants, as outlined in Section II.D.18. is not eligible for Self-Referred Covered Services.
4. Claims for Self-Referred Covered Services must be received by First Priority Health with one (1) year from the date of service.

Section III. Exclusions

A. The following are not covered services under the Agreement:

1. Any service obtained by or on behalf of a Participant without prior authorization by the Participant's Primary Care Physician and when appropriate, by First Priority Health, except as described in Section II.E., F., G., H., and L. of this summary.
2. Cosmetic procedures for cosmetic purposes, except those performed to correct medically diagnosed congenital defects and birth abnormalities or a condition resulting from an accident or illness.
3. Unless otherwise stated in this summary, all dental services related to the care, filling, removal or replacement of teeth and treatment of diseases of the teeth or gums, including but not limited to apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, treatment of temporomandibular joint dysfunction with intraoral prosthetic devices, or any other method to alter the vertical dimension of the bite, alveolectomy and treatment of periodontal disease.
4. Services or supplies which First Priority Health initially determines are Experimental or Investigative in nature or for the Covered Services related to them; First Priority Health's procedure in determining whether the use of any treatment,

procedure, Provider, equipment, drug, device or supply is Experimental or Investigative is set forth in Section V, Other Provisions section of this summary.

5. Care of any illness or injury suffered after the Participant's Effective Date of coverage as a result of any act of war.
6. Coverage of non-First Priority Health donor in a transplant procedure unless the recipient of the transplant is a Participant. In the event a Participant is the recipient, coverage will be provided under the Agreement for a live non-First Priority Health donor to the extent covered services are unavailable from any other source. The purchase of human organs which are sold rather than donated to transplant recipients are not covered.
7. Charges to the extent payment has been made under Medicare or would have been made if the Participant had applied for Medicare and claimed Medicare Covered Services.
8. Treatment of mental retardation, defects, deficiencies and learning disabilities. This exclusion does not apply to Mental Health Care Services as described in Section II.F. or to medical treatment of retarded Participants in accordance with the covered services provided in Section II.
9. Care for conditions that state or local law requires to be treated in a public facility.
10. The cost of securing the services of professional blood donors.
11. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails

- (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.
12. Provision of personal convenience items or service such as barber services, guest meals, radio and television rentals, and other like items and services.
 13. Custodial care, domiciliary care or rest cures.
 14. Weight reduction programs.
 15. Drugs, medications and injectables, including fertility injectables when used for the purpose of ovulation and contraceptives when used for the purpose of birth control, except as provided in Section II.
 16. Special medical reports, unless directly related to treatment of a Participant.
 17. Private duty or special nursing care.
 18. Payment for services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates identification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by state law.
 19. Chronic Alcohol and/or Drug Abuse treatment, except as provided by Section II.E.
 20. Long-Term Residential Care.
 21. Therapy or rehabilitation, except as provided by Section II.I.
 22. Reversal of voluntary sterilization.
 23. Transsexual surgery or related services.
 24. Elective abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered. Therapeutic abortions are covered only when Medically Necessary and approved by First Priority Health's Medical Direct.
 25. Immunizations obtained for the purpose of international travel or which are work related.
 26. Costs related to any court appearance, proceeding or hearing.
 27. Charges for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers' compensation, occupational disease or similar type legislation. This exclusion applies regardless of whether the Participant claims the covered service or compensation.
 28. Charges for treatment of obesity, except when surgical treatment of morbid obesity is Medically Necessary.
 29. Orthoptics (a technique of eye exercise designed to correct the visual axes of eyes not properly coordinated for binocular vision).
 30. Services or supplies received from a dental or medical department established primarily for treatment of employees or Participants and maintained by or on behalf of an employer, a mutual covered service association, labor union, trust or similar person or group.
 31. Charges incurred prior to the Participant's Effective Date or during an Inpatient admission that commenced prior to the Participant's Effective Date.
 32. Charges incurred after the date of termination of the Participant's coverage, except as provided in this summary.
 33. Services or supplies for personal hygiene and convenience items such as, but not

limited to, air conditioners, humidifiers, physical fitness equipment and air filtering machines.

34. Charges for telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form.
35. Charges for which the Participant has no legal obligation to pay.
36. Charges which are recoverable by or on behalf of the Participant in any action at law or in compromise or settlement of a claim against a party, other than an insurer of the Participant, unless the Participant furnished such information as First Priority Health may require to facilitate enforcement of its rights.
37. Charges for Inpatient admissions and home care services not certified as eligible by the Participant's Primary Care Physician and First Priority Health's Utilization Management Department.
38. Spinal Manipulation.
39. Mandated treatment, including court ordered treatment, unless such treatment is Medically Necessary.
40. Corneal surgery to change the shape of the cornea which will correct vision problems such as myopia (nearsightedness), hyperopia (farsightedness) and astigmatism. The correction of astigmatism resulting from trauma or from previously eligible surgery, including, but not limited to, cataract and corneal surgery, is eligible for payment.
41. In Vitro Fertilization; Gamete Intra Fallopian Tube Transfer (a form of In Vivo Fertilization) and Zygote Intra Fallopian Tube Transfer (a form of In Vitro Fertilization) including the drugs, diagnostic monitoring (ultrasound) and

other services and supplies related to these procedures.

42. Durable Medical Equipment, Prosthetics and Orthotics, with the exception of oxygen and the initial equipment necessary to utilize oxygen. Replacement of the initial oxygen equipment is not covered.
43. Inpatient care and Partial Hospitalization for mental health care services.
44. Preventive dental care.
45. Paramedics.

Section IV. Participant Eligibility

At the direction of the Plan, First Priority Health will enroll the Subscriber and his/her spouse and all unmarried and unemployed dependent children under 19 years of age as participants for the coverage described herein.

Each eligible dependent child participant is covered from birth until: (a) the end of the calendar year in which he/she reaches their 19th birthday, (b) the end of the month in which he/she marries or becomes employed or (c) the end of any period during which he is incapable of self-support because of a disabling abnormality or condition of illness or injury. Eligibility for continuation of such disabled children will be initially determined by First Priority Health.

Unmarried dependent student participants will be covered to age 23 if they are attending on a full time* basis an accredited college, university, technical or specialized school and are pursuing a course of study requiring at least 2 years which will lead to a degree or certificate upon completion.

- * 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. The initial determination of eligibility will be made by First Priority Health.

Section V. Other Provisions

A. IDENTIFICATION CARD

The identification card issued by First Priority Health to a Participant pursuant to the Agreement is for identification purposes only. Possession of an identification card confers no right to services or covered services under the Agreement, and misuse of such identification card may be grounds for initial termination of a Participant's coverage pursuant to Section IV. If the Participant who misuses the card is the Subscriber, coverage may be terminated for the Subscriber as well as any Dependents. To be eligible for services or benefits under the Agreement, the holder of the card must be a Participant on whose behalf all applicable administrative fees under the Agreement have been paid. Any person receiving services or covered services which he or she is not entitled to receive pursuant to the provisions of the Agreement shall be charged for such services or covered services at prevailing rates.

If any Participant permits the use of his or her identification card by any other person, such card may be retained by First Priority Health, and all rights of such Participant and his or her Dependents, if any, pursuant to the Agreement shall be initially terminated immediately, subject to the Grievance Procedure attached in Exhibit C of the Agreement.

If a Subscriber terminates coverage with First Priority Health, it is the Plan's responsibility to obtain the identification cards of the Subscriber and affiliated Participant and to return the cards to First Priority Health.

B. MEDICAL NECESSITY

Participants will receive covered services under the Agreement only when Medically Necessary. First Priority Health may determine whether any covered service

provided was Medically Necessary, and First Priority Health has the option to initially select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to Medical Necessity are subject to review by First Priority Health Medical Director, or his/her Physician designee.

C. EXPERIMENTAL OR INVESTIGATIVE SERVICES

The Medical Director of First Priority Health shall have initial authority to determine whether the use of any treatment, procedure, Provider, equipment, drug, device or supply (each of which is herein after called a "Service") is Experimental or Investigative.

- a. If, in making that initial determination, the Medical Director 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 facility or of a written investigational or research protocol of another facility studying substantially the same Service; or (2) the subject of a written informed consent used by the treating facility which refers to the Service as experimental, investigative, educational or research; or (3) the subject of an ongoing phase I, II or III clinical trial, the Service shall be deemed to be Experimental or Investigative.
- b. If, in making that initial determination, the Medical Director finds that neither a protocol, an informed consent nor an ongoing clinical trial, as described above, exist, then the Medical Director may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature:
 - (1) that the Services is recognized by a majority of those practicing the appropriate medical specialty as

being safe and effective for use in the treatment of the particular condition in question; and

- (2) that the Service has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources with measurable results supported by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
- (3) that, over time, the Service leads to improvements in health outcomes, i.e. the beneficial effects of the Service outweigh any harmful effects of the Service; and
- (4) that the Service is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable; and
- (5) that improvement in health outcomes is possible in standard conditions of medical practice outside clinical investigatory settings.

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

- c. If, in making the initial determination, the Medical Director 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 services is rendered; (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.

D. HOSPITAL AND FACILITY OTHER PROVIDER RULES

Participant is subject to all the rules and regulations of each Hospital and other facility in which covered services are provided.

E. REFUSAL OF TREATMENT

Participant may, for personal reasons, refuse to accept procedures, medicines or courses of treatment recommended by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Participant) believes that no professionally acceptable alternative exists, and if after being so advised, Participant still refuses to follow the recommended treatment procedure, Participant will receive no further treatment for the condition involved. In such case neither the Providers nor First Priority Health will have further responsibility to provide any of the covered services available under the Agreement for treatment of such condition. First Priority Health will provide written notice to Participant of a decision not to render further treatment for a particular condition. The decision is subject to the Grievance Procedure attached in Exhibit C of the Agreement. Treatment of the condition involved will be resumed in the event Participant agrees to follow the recommended treatment or procedure.

F. NON-ASSIGNMENT OF PAYMENT OF BENEFITS

No person other than a Participant is entitled to receive benefits for Covered Services under this Agreement.

Furthermore, First Priority Health will arrange payments of Covered Services to be made directly to Participating Providers furnishing Covered Services under this Agreement. However, First Priority Health reserves the right to make payments directly to Participants.

The right of a Participant to receive payment is not assignable nor may the right to receive Covered Services be transferred by a Participant.

G. LEGAL ACTION

No action at law or in equity may be maintained against First Priority Health for any expense or bill unless brought within the statute of limitations for such cause of action.

H. PHYSICIAN – PATIENT RELATIONSHIP

Participating Physicians maintain the physician-patient relationship with Participant and are solely responsible to the Participant for all Medical Services which are rendered by Providers.

I. CONFIDENTIALITY

Information contained in the medical records of Participants and information received from Physicians, surgeons, Hospitals or other health professionals incident to the doctor-patient relationship or hospital-patient relationship shall be kept confidential in accordance with the Agreement.

J. LIMITATION ON SERVICES

Except in cases of emergency as provided under Section II.G. of the Benefit Summary, services are available only from Participating Providers, and First Priority Health shall have no liability or obligation whatsoever on account of any service or covered service sought or received by a Participant from any Provider or other person, entity, institution or organization unless prior arrangements are made by First Priority Health.

K. ALTERNATIVE TREATMENT PLAN

Notwithstanding anything in the Agreement to the contrary, First Priority Health may, upon consideration of the Plan, 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 Primary Care Physician and/or the Attending Physician and the Participant.