

WILKES UNIVERSITY
EMPLOYEE WELFARE BENEFIT PLAN

BlueCare HMO
Group # 080648-000 & 080648-099

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Effective: 06/01/2011

Restated:

Third Party Administrator:
First Priority Health
19 North Main St.
Wilkes-Barre, PA 18711
Phone (800) 822-8753

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ESTABLISHMENT OF THE PLAN

THIS *PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION* (the "*summary plan description*"), made by Wilkes University (the "*Company*" or the "*Plan Sponsor*") as of June 1, 2011, hereby sets forth the provisions of the Wilkes University Employee Welfare Benefit Plan (the "*Plan*").

What is the effective date of the *Plan*?

The *summary plan description* is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

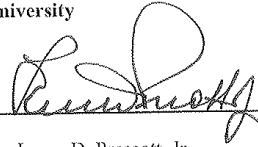
Adoption of the *summary plan description*

The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* represents both the *plan document* and the *summary plan description*, which is required by *ERISA*. This *summary plan description* amends and replaces any prior statement of the health care coverage contained in the *Plan* or any predecessor to the *Plan*.

IN WITNESS WHEREOF, the *Plan Sponsor* has caused this *summary plan description* to be executed.

Wilkes University

By: _____



Name: Loren D. Prescott, Jr.

Title: Vice President of Finance and General Counsel

Date: May 20, 2011

Record of Plan Amendments

Amendment Number	Amendment Date	Subject of Amendment

GENERAL PLAN INFORMATION

What is the purpose of the Plan?

The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The *Plan* is not a contract of employment between you and your *participating employer* and does not give you the right to be retained in the service of your *participating employer*.

The purpose of this *summary plan description* is to set forth the terms and provisions of the *Plan* that provide for the payment or reimbursement of all or a portion of certain medical expenses. The *summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *covered person*.

General Plan Information You Should Know

Name of Plan: Wilkes University – BlueCare HMO Plan

Plan Sponsor: Wilkes University
Human Resources Department
84 West South Street
Wilkes-Barre, PA 18766
Phone: (570) 408-4644

**Plan Administrator:
(Named Fiduciary)** Wilkes University
Human Resources Department
84 West South Street
Wilkes-Barre, PA 18766
Phone: (570) 408-4644

Plan Sponsor ID No. (EIN): 24-0795506

Calendar Plan Year: June 1 through May 31

Plan Number: 501

Plan Type: Medical & Prescription Drug

Third Party Administrator: First Priority Health
19 North Main St.
Wilkes-Barre, PA 18711
Phone (800) 822-8753

Participating Employer(s): Wilkes University

Agent for Service of Process: Wilkes University
Human Resources Department
84 West South Street
Wilkes-Barre, PA 18766
Phone: (570) 408-4644

The *Plan* shall take effect for each *participating employer* on the *effective date* shown on the cover, unless a different date is set forth above. The *Plan* is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

As a full or part-time *employee* regularly scheduled to work at least 35 hours per pay period, you are eligible for coverage on the first of the month following your date of hire for active employment.

You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

You are not eligible to participate if you are a temporary, leased or seasonal employee, or an independent contractor.

Are my dependents eligible to participate in the *Plan*?

Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;
- The date coverage for *dependents* first becomes available under the *Plan*; and
- The first date upon which you acquire a *dependent*.

Please note: You must be covered under the *Plan* in order to cover any *dependents*.

No *dependent child* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent*.

- To be eligible to enroll as a *Dependent*, a person must be: a) the spouse or Same-Sex Domestic Partner of an Insured; or b) the Insured's, Insured's Spouse's or Insured's Same-Sex Domestic Partner's unmarried child(ren) including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children covered under guardianship. First Priority Life may require legal written documentation to verify the relationship between a *Dependent* and an Insured. First Priority Life also reserves the right to request documentation of at least three (3) of the following prior to commencing coverage for a Same-Sex Domestic Partner:
 - a. a Same-Sex Domestic Partner Agreement;
 - b. a joint mortgage or lease;
 - c. a designation of one of the partners as beneficiary in the other partner's will;
 - d. a durable property and health care powers of attorney;
 - e. a joint title to an automobile, or joint bank account or credit account; or
 - f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

Once enrolled, a Same-Sex Domestic Partner must continue to meet the eligibility criteria set forth herein. The Insured must notify First Priority Life in writing as soon as the Same-Sex Domestic Partnership has been terminated. Upon termination of the Same-Sex Domestic Partnership, coverage of the former Same-Sex Domestic Partner and the child(ren) of the former Same-Sex Domestic Partner will terminate at the end of the month in which the partnership was terminated.

The Insured has the responsibility to inform First Priority Life of the termination of his/her Same-Sex Domestic Partnership and when either party no longer meets all of the criteria of a Same-Sex Domestic Partner, as defined in this Policy, within thirty-one (31) days of such change. First Priority Life reserves the right to request proof of the

dissolution of that Same-Sex Domestic Partnership. Upon termination of that Same-Sex Domestic Partnership, coverage of the former Same-Sex Domestic Partner and the child(ren) of the former Same-Sex Domestic Partner will terminate at the end of the month in which the partnership was terminated.

- Dependent children must be:
 - At the direction of the Plan, Less than age twenty six (26). Coverage will continue until the end of the month in which the Dependent reaches age twenty six (26); or
 - At the direction of the Plan, age twenty six (26) or older, but incapable of self-support due to mental retardation or physical disability, either of which commenced prior to age twenty six (26) ; and has been continuously present from then and has been certified by a Physician who is knowledgeable of the Dependent's present condition; or At the direction of the Plan, eligibility shall continue past the limiting age for children who are incapable of self sustaining employment due to mental retardation, physical handicap, mental illness or developmental disability if such disability commenced while the child was a validly enrolled Dependent on the parent's Agreement and has been certified as disabled by First Priority Life. If a disabled Dependent child is covered under a parent's Agreement at the time this language becomes effective, the disabled Dependent will be eligible for coverage under this Agreement as long as he/she is certified as a disabled Dependent by First Priority Life.
 - At the direction of the Plan, Newborn children will be treated as Dependents from birth subject to enrollment requirements. Coverage shall include sickness or injury, including medically diagnosed congenital defects, birth abnormalities, pre-maturity, and routine nursery care. Coverage of a newborn child of a Participant, a newborn adopted child of a Participant or a newborn child placed for adoption of a Participant is effective at the time of birth and shall automatically extend for a period of thirty-one (31) days following birth. To continue coverage for the child beyond the thirty-one (31) day period by enrolling the newborn child as a dependent within thirty-one (31) days following the birth of the child.

The determination of eligibility will be made by the Plan.

When will we become *covered persons in the plan*?

Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the first day of the month following the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 30 days following the date of eligibility.
- For a *dependent child* who is born after the date your coverage becomes effective:
 - The *dependent child* will be covered from the moment of birth for 31 days. If you wish to continue coverage beyond this 31-day period, you must make written application for coverage and agree to any required contribution **during the first 31-day period from birth.**
- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the first day of the month following the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required contributions, within 31 days of the date of eligibility.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

You and your *dependents* may enroll for coverage during the *Plan's* annual open enrollment period, which is typically mid-April to mid-May in each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on the first day of June following the open enrollment period, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the first day of the month following your completion of the *waiting period*.

Are there any other exceptions for enrollment?

Special Enrollment Periods

This *Plan* provides special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period..

Loss of Other Coverage

If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 30 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents*:

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan*;
- You are not currently enrolled under the *Plan*;
- When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan*, and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.

You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the *Plan*.

New Dependent

If you acquire a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must make written application for special enrollment no later than 30 days after you acquire the new *dependent*. For example, if you are married on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents*:

You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:

- You are eligible for coverage under the terms of this *Plan*, and
- You have acquired a new *dependent* through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:

- For a marriage, on the date of the event.
- For a birth, on the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Special Enrollment for Previously Enrolled Covered Persons

Dependents who had ceased to be eligible to enroll in the *Plan* prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin April 15, 2011. All *dependents* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of *dependent* coverage of *children* ended before age 26, are eligible to enroll, or re-enroll in the *Plan* or coverage under this special enrollment period. Coverage for *dependents* who enroll through this special enrollment opportunity must take effect on June 1, 2011.

Covered persons who were previously enrolled, but were terminated from *Plan* participation because of a prior lifetime limitation provision shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin April 15, 2011. All *covered persons* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for coverage) because the prior lifetime limitation had been reached, are eligible to enroll, or re-enroll in the *Plan* or coverage under this special enrollment period. Coverage for *covered persons* who enroll through this special enrollment opportunity must take effect on June 1, 2011.

Additional Special Enrollment Rights

Employees and *dependents* who are eligible but not enrolled are entitled to enroll under the following circumstances:

- The *employee's* or *dependent's* Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the *employee* requests coverage under the *Plan* within 60 days after the termination; or
- The *employee* or *dependent* becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the *employee* requests coverage under the *Plan* within 60 days after eligibility is determined.

What if a court orders coverage for a *child*?

Federal law requires the *Plan*, under certain circumstances, to provide coverage for your *children*. The details of these requirements are summarized below. Be sure you read them carefully

The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a "medical child support order" ("*MCSO*") or "national medical support notice" ("*NMSN*") that is a "qualified medical child support order" ("*QMCSO*") if the *child* named in the *MCSO* is not already covered by the *Plan* as an eligible *dependent*, once the *Plan Administrator* has determined that the order or notice meets the standards for qualification set forth below.

“*Alternate recipient*” shall mean any *child* of a *covered person* who is recognized under a *MCSO* as having a right to enrollment under this *Plan* as the *covered person’s eligible dependent*. “*MCSO*” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *covered person’s child* or directs the *covered person* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

“*NMSN*” shall mean a notice that contains the following information:

- Name of an issuing state agency;
- Name and mailing address (if any) of an *employee* who is a *covered person* under the *Plan*;
- Name and mailing address of one or more *alternate recipients* (i.e., the *child* or *children* of the *covered person* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipients(s)*); and
- Identity of an underlying child support order.

“*QMCSO*” is an *MCSO* that creates or recognizes the existence of an *alternate recipient’s* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *covered person* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *QMCSO*, it must clearly specify the following:

- The name and last known mailing address (if any) of the *covered person* and the name and mailing address of each *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *NMSN* shall be deemed a *QMCSO* if it:

- Contains the information set forth above in the definition of “*NMSN*”;
 - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the employer and the *Plan Administrator* will assume that all are designated; or
 - Informs the *Plan Administrator* that, if a group health plan has multiple options and the *covered person* is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the *child* will be enrolled under the *Plan’s* default option (if any); and
- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan*, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to *covered persons* without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO’s, as described in Social Security Act §1908.

Upon receiving a *MCSO*, the *Plan Administrator* shall, as soon as administratively possible:

- Notify the *covered person* and each *alternate recipient* covered by the order (at the address included in the order) in writing of the receipt of such order and the *Plan’s* procedures for determining whether the order qualifies as a *QMCSO*; and
- Make an administrative determination if the order is a *QMCSO* and notify the *covered person* and each affected *alternate recipient* of such determination.

Upon receiving a *NMSN*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the *child* is available under the terms of the *Plan* and, if so:
 - Whether the *child* is covered under the *Plan*; and
 - Either the *effective date* of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *MCSO* or *NMSN*; and
- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

When you and your spouse are both *covered persons*

When both you and your spouse are covered *employees*, and you have family coverage for *dependent children*, the *Plan* will allow one spouse to be treated as a *dependent* for purposes of calculating the *family unit deductible* and *out-of-pocket expense* amount. This will allow for the full benefit of family coverage and reduce the *out-of-pocket expenses* for the *family unit*. The spouse with the later date of hire will be treated as a *dependent* for the purposes stated in this section unless the *Plan Administrator* determines otherwise.

When you change your coverage status between that of an *employee* and a *dependent*, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current *plan year deductible* and *out-of-pocket expense* limit, and any amounts applied toward *Plan* maximums will be carried forward.

SELECTION OF YOUR HEALTH CARE PROVIDER

This *Plan* generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the *Plan Administrator*. For children, you may designate a pediatrician as the primary care provider.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan*, including *deductibles*, copayments and the coinsurance percentage that is not paid by the *Plan*. This is called “*out-of-pocket expense*.”

Deductibles and copayments are shown in the “Schedule of Benefits.”

Reimbursement for these types of *covered expenses* will continue at the percentage payable shown in the “Schedule of Benefits,” subject to the *Plan* maximums.

In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the “Schedule of Benefits” section.

The *Plan* will not reimburse any expense that is not a *covered expense*. In addition, you must pay any expenses to which you have agreed that are in excess of the *usual, customary and reasonable fees*, and any penalties for failure to comply with requirements of the “Cost Containment Provisions” section or penalties that are otherwise stated in the *Plan*. None of these amounts will accumulate toward your *out-of-pocket expense* limit.

If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your *out-of-pocket expense* limit, please contact the *third party administrator* for assistance.

SCHEDULE OF BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, “Medical Benefits” and “Exclusions and Limitations.” You may find the “Definitions” section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as “Cost Containment Provisions,” and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *third party administrator* or the *Plan Administrator* for assistance.

Primary care providers

A current list of HMO providers is available, without charge, through the *Third Party Administrator’s* website located at www.bnepa.com.

Each *covered person* must select a *primary care provider* and the *physician-patient* relationship shall be maintained. The *covered person*, together with his or her *physician*, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care.

Benefit Information	BlueCare HMO	
	Participant Responsibility	Limitations
Benefit Period	Calendar Year	Calendar Year
Deductible (per benefit period) Note: All services are subject to deductible unless otherwise noted.	None	
Coinsurance	0% of Allowable Charge	
Coinsurance Maximum	None	

Benefit Information	BlueCare HMO	
	Participant Responsibility	Limitations
Lifetime Maximum	Unlimited	
Precertification Penalty	None	
Physician Office Visits	\$20 copay	
Specialist Office Visits	\$40 copay	
Newborn Children	Covered in Full	
Routine GYN Exams/Pap Smear	Covered in Full.	One Routine Exam per benefit period
Routine Physical Exams	Covered in Full	Preventive medical evaluations and management exams
Mammography screenings/diagnostic	Covered in Full	
Pediatric Immunizations	Covered in Full	
Nutritional Therapy	Covered in full	6 visit maximum per benefit period
Routine colorectal cancer & prostate cancer screening	Covered in Full	
Emergency Room Visit	\$100 copay waived if admitted	
Ambulance Emergency Land Transport	Covered in Full	
Ambulance Non-Emergency Land Transport	\$50 copay	
Ambulance Air/Water/Train Transport	\$250 copay	
Inpatient Hospital Services incl. maternity (facility & professional)	\$100 copay per admission	Unlimited Days
Inpatient Rehabilitation	\$100 copay per admission	45 days per benefit period
Skilled Nursing Care	\$100 copay per admission	60 days per benefit period
Transplants	Covered In Full	
High-Tech Imaging (MRI, MRA, CT, PET scans, nuclear cardiology)	\$75 copay per test	
Diagnostic testing (lab tests, x-ray, etc)	Covered in Full	
Radiation, dialysis or chemotherapy	Covered in Full	
Maternity Care (outpatient physician visits)	\$40 copay, initial office visit	Neonatal circumcision is covered
Cardiac Rehabilitation	Covered in Full	36 visits per benefit period

Benefit Information	BlueCare HMO	
	Participant Responsibility	Limitations
Physical, Occupational & Speech Therapy	\$40 copay	45 visits combined maximum per benefit period
Respiratory Therapy & Pulmonary Rehabilitation Therapy	Covered in Full	18 visits each per benefit period
Outpatient Surgery	\$100 copay	
Chiropractic manipulative benefits	\$40 copay	12 treatments per benefit period; Limited to age 13 and up. All services billed by a chiropractor are applied to the chiropractic benefit.
Durable Medical Equipment/ Orthotics/ Prosthetics	Covered in Full	unlimited benefit period maximum
Ostomy Supplies	50% Amounts are applied to coinsurance maximum, but will always pay at 50%	ostomy supplies, tracheostomy and urinary catheters up to \$1,000 maximum per benefit period.
Autism Spectrum disorders	Covered in Full	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21. Coverage is subject to any applicable copays, coinsurance, and/or deductible. \$36,000 limit per member per benefit period.
Home Health Care	\$40 copay	Home Health Aides are covered.
Hospice	Covered in Full	180 days per lifetime
Private Duty Nursing	Not Covered	
Oral Surgery	Covered In Full	
Bony Impacted Wisdom Teeth	50% of Allowable Charge	Covered in office setting only.
Morbid Obesity Precertification required.	\$2,000 copay per procedure for medically necessary gastric bypass; \$1,000 copay medically necessary panniculectomy.	Once per lifetime.
Infertility	Covered In Full Applicable copay applies for office visits.	Diagnostic services leading up to the diagnosis of infertility
In-Vitro Fertilization	Not Covered	
Artificial Insemination	Covered In Full 3 attempts per lifetime	
Non-elective Abortion	Covered in Full	
Voluntary Sterilization	Covered In Full	
Inpatient Mental Health Services	\$100 copay per admission	Unlimited Days
Outpatient Mental Health Services	Covered In Full	Unlimited Visits
Inpatient Non-hospital Residential substance abuse treatment.	\$100 copay per admission	Unlimited Days
Outpatient Substance Abuse	Covered In Full	Unlimited Visits

Benefit Information	BlueCare HMO	
	Participant Responsibility	Limitations
Detoxification	\$100 copay per admission	Unlimited Days
Outpatient Mental Health/Substance Abuse Emergency Room Visit	\$100 copay waived if admitted Not subject to deductible	Unlimited Visits
Prescription Drugs Retail (30 day supply) (Quantity limits, select home delivery, mandatory generic, step therapy, prior authorization may apply)	Tier 0 - \$0 Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$50	
Prescription Drugs Mail Order (90 day supply) Quantity limits, select home delivery, mandatory generic, step therapy, prior authorization may apply)	Tier 0 - \$0 Tier 1 - \$30 Tier 2 - \$70 Tier 3 - \$150	
Oral contraceptives	Covered	
Specialty Injectable Network	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Weight Loss Drugs	Not Covered	

MEDICAL BENEFITS

Please refer to the “Cost Containment Provisions” section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan*. Reimbursement will be made according to the “Schedule of Benefits,” and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

Covered 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 specialists. Payment will be made for Covered Services provided by Providers who are not in the First Priority Health Network, if Medically Necessary and upon Prior Authorization by the Participant’s Primary Care Physician or participating Specialist Physician and First Priority Health and for Outpatient Emergency Services. Coverage for the removal of bony impacted wisdom teeth, however, is limited to services of Participating Providers within the First Priority Health Network as discussed in this Section. In accordance with First Priority Health’s policies and procedures, certain procedures/surgeries performed in an acute-care Hospital’s short procedure unit or a free-standing surgical facility and certain diagnostic tests/scans require Prior Authorization, regardless of Provider.

A. PRIMARY CARE PHYSICIANS AND PARTICIPATING SPECIALIST PHYSICIANS

Covered Services are provided for Medical Care, visits and consultations when Medically Necessary and at or through the Participant’s Primary Care Physician’s office of record, or by a participating Specialist Physician. Participants may utilize their Primary Care Physician for obstetrical services. When Copayments apply to obstetrical services provided by a Primary Care Physician or a participating Specialist Physician, Copayments only apply to the first visit. For such obstetrical services, there is no charge after the first visit. Subsection L. Maternity and Gynecological Services of this Description of Covered Services Section describes obstetrical services. Services by a Primary Care Physician include the examination, diagnosis, and treatment of an illness or injury and routine office visits. Adult care includes routine physical examinations, once per Benefit Period, and additional examinations when Medically Necessary, including a complete medical history plus necessary Diagnostic Services.

Covered Services by participating Specialist Physicians, if Medically Necessary, include the examination, diagnosis, and treatment of an illness or injury, as well as coverage for vision care to diagnose and treat a disease process involving the anatomy of the eye and for annual eye examinations for Participants diagnosed with diabetes. Coverage will be provided for the initial prescription of cataract glasses or contact lenses, with or without an implant, after cataract Surgery. Post-cataract prescription glasses or contact lenses are limited to a lifetime Maximum of \$350 per Participant or as indicated in the Outline of Coverage. This Maximum allowance includes both eyes.

Payment will be made for Covered Services provided by Providers who are not in the FPH Network, if Medically Necessary, and upon Prior Authorization by the Participant's Primary Care Physician or participating Specialist Physician and First Priority Health.

B. HOSPITAL SERVICES

Prior Authorization requirements must be followed as discussed in Section CC – Care Coordination. Inpatient emergency admissions must be reviewed within forty-eight (48) hours of the admission, or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what First Priority Health has authorized. Inpatient Copayments, Deductibles and/or Coinsurance included in the Outline of Coverage apply per admission.

1. Room and Board

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

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

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

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

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

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

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

2. Ancillary Services

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

- a. meals, including special meals or dietary services as required by the patient's condition;
- b. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- c. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by First Priority Life;
- d. oxygen and oxygen therapy;
- e. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Subsection Z – Blood and Blood Plasma of this Section;
- f. anesthesia and the supplies and use of anesthetic equipment;
- g. Diagnostic Services;
- h. Therapy Services;
- i. Inpatient rehabilitation therapy limited to forty-five (45) days per Benefit Period or as indicated in the Schedule of Benefits and requires Prior Authorization;
- j. all FDA-approved drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;
- k. use of special care units, including, but not limited to, intensive or coronary care; and
- l. pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a diagnosis.

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

C. OBSERVATION STATUS

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

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

D. EMERGENCY CARE BENEFITS WITHIN AND OUTSIDE THE FIRST PRIORITY HEALTH NETWORK

Emergency care Covered Services includes treatment and services in the Outpatient department of a Hospital.

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

If accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical Covered Services. Visits performed in the Outpatient department of a Hospital

that are follow-up to emergency accident care and medical Emergency Services are classified and payable as Outpatient Covered Services.

First Priority Health will reimburse the Provider or Participant for the reasonable cost of emergency accident services or a medical Emergency Service (less appropriate Copayments) performed within or outside the First Priority Health Network (including out of the country), regardless of Provider.

Reimbursement – First Priority Health may limit reimbursement for emergency accident services, or a medical Emergency Service by a Non-Participating Provider, located either within or outside the First Priority Health Network, to those expenses which are incurred up to the time the Participant is determined to be medically able to travel or to be transported to a First Priority Health Participating Provider. Reimbursement will be subject to payment by the Participant of all appropriate Copayments, deductibles and coinsurance. Once a Participant is stabilized, to continue coverage First Priority Health reserves the right to transfer a Participant's care from a Non-Participating Provider to a Participating Provider. When processing the claim for reimbursement, First Priority Health shall consider both the presenting symptoms and the services provided. A Non-Participating Provider may bill a Participant for the difference between the amount First Priority Health reimburses the Provider and the billed charges. The Participant is responsible for a Copayment in the amount shown in the Outline of Coverage for Emergency Service provided by a Non-Participating Provider plus the difference between the amount First Priority Health reimburses the Provider and the billed charges. If the Member is admitted to the Hospital from the emergency room, the emergency room Copayment is waived.

The Participant is responsible for a Copayment for each emergency visit to a Physician's office and a Copayment for each emergency visit to a Hospital Outpatient department or emergency room in the amount shown in the Outline of Coverage. If the Participant is admitted to the Hospital from the emergency room, the emergency room Copayment is waived.

The Participant will not be responsible for an emergency room Copayment in excess of a Primary Care Physician Copayment if the Participant (prior to receiving emergency room services) has been referred to the emergency room by a Primary Care Physician and the services could have been provided in the Primary Care Physician's office. The Primary Care Physician is required to notify First Priority Health within five (5) Business Days of the date of service or as soon as reasonably possible.

E. OUT-OF-AREA COVERED SERVICE

1. Urgent Care – Care for an unexpected illness or injury that is not life-threatening, but which cannot be reasonably postponed until the Member returns home. Examples of urgent care include, but are not limited to, a fever, cold or the flu. For urgent care outside of the area serviced by First Priority Health's Network of Providers, Participants can receive coverage through BlueCard. Prior to receiving urgent care, the Participants must call the toll-free number listed on the Identification Card for instruction on availing themselves of this coverage. Appropriate Copayments will apply.

2. Follow-Up Care – Participants, who are currently receiving ongoing treatment for an illness or injury and plan to travel outside of the area serviced by First Priority Health's Network of Providers, can receive coverage through BlueCard. In order to receive Covered Services, the Participant must contact their Primary Care Physician or Participating Specialist Physician for Prior Authorization to a Participating Provider of a Host Plan. The Primary Care Physician or Specialist Physician must submit a BlueCard Transfer of Medical Information Request Form to First Priority Health for approval prior to the service being rendered. Appropriate Copayments will apply.

3. Guest Membership – Participants, who are temporarily out of the area serviced by First Priority Health's Network of Providers for at least ninety (90) days, may contact First Priority Health for an Application for a Guest Membership. If the Participant's Application is approved, the Participant will receive Covered Services in accordance with the host HMO's Covered Services and provider contracts. Copayments will be in accordance with the host HMO Covered Service Agreement.

4. Students – Participant students, who are out of the area serviced by First Priority Health's Network of

Providers, may receive Inpatient and Outpatient Alcohol and/or Drug Abuse Treatment Covered Services and Mental Health treatment through BlueCard, if the Primary Care Physician and the Community Behavioral Healthcare of Pennsylvania (CBHNP) coordinate the care.

F. SURGERY

1. Surgical Covered Services

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

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

- Upon Pre-Certification, Surgery benefits are covered for the surgical treatment of Morbid Obesity, provided the Insured is at least eighteen (18) years of age and has no prior history of bariatric Surgery. If the preferred Coinsurance on the Declaration Page and Schedule of Benefits indicates "none," a Copayment of \$2,000 applies for the procedure when performed by a Preferred Provider. Copayments are the responsibility of the Insured.

- When a panniculectomy is Medically Necessary, upon Pre-Certification it is limited to one (1) procedure per lifetime for those eighteen (18) years of age or older. If the preferred Coinsurance on the Declaration Page and Schedule of Benefits indicates "none," a Copayment of \$1,000 applies for the procedure when performed by a Preferred Provider. Copayments are the responsibility of the Insured.

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

- Covered surgical procedures shall also include routine neonatal circumcision and any voluntary surgical procedure for sterilization regardless of Medical Necessity. Surgery performed for the reversal of sterilization is not covered.

- Benefits are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:
 - a. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
 - b. Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
 - c. Physical complications of all stages of Mastectomy, including lymphedemas.

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

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

2. Assistant Surgeon

Covered Services will be payable for services by an assistant surgeon who actively assists the operating

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

3. Removal of Bony Impacted Wisdom Teeth

Coverage for the removal of partially or totally bony impacted wisdom teeth, when performed by a Participating Provider in other than a Hospital or Ambulatory Surgical Facility, will be covered, as specified in the schedule of Benefits.

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

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

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

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

Local anesthesia and conscious sedation are covered regardless of setting.

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

Dental procedures are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions.

Covered Services will be payable for Physician, Hospital or Ambulatory Surgical Facility charges in connection with dental procedures or dental Surgery performed in a Hospital or Ambulatory Surgical Facility when approved by a Medical Director of First Priority Health under the following circumstances:

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

5. Oral Surgery

Dental or oral Surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Service under the Policy only for treatment of diseases and injuries of the jaw, head and neck. Surgery for the treatment of other than diseases of the teeth or gums, are not covered.

Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures are excluded from benefits for oral Surgery unless such procedures were for the treatment of accidental bodily injury.

6. Dental Services related to Accidental Injury

Dental services rendered by a Professional Provider and/or a Facility Provider, which are required as result of accidental injury to the jaws, natural teeth, mouth or face, are covered. Injury as a result of chewing or biting shall not be considered an accidental injury.

Dental implants are excluded from benefits as set forth in the exclusions.

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

Dental services directly associated with early childhood caries (ECC), prior to age four (4), are limited to one (1) treatment per Participant per lifetime or as indicated on the Schedule of Benefits.

G. ANESTHESIA

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

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

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

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

Local anesthesia and conscious sedation are covered.

H. SECOND SURGICAL OPINION

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

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

I. TRANSPLANT SURGERY

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

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

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

Pre-certification is required as set forth in the Care Coordination Section.

J. CONCURRENT CARE

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

K. CONSULTATIONS

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the Primary Care Physician's office of record. Consultations do not include staff consultations, which are required by Facility Provider's rules and regulations. Covered services are limited to one (1) consultation per consultant during any Inpatient confinement.

L. MATERNITY AND GYNECOLOGICAL SERVICES

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

1. Gynecological Services

Routine annual gynecological examinations including a pelvic examination, clinical breast examination and one routine Papanicolaou smear for female Participants per Benefit Period. Participants can utilize their Primary Care Physician for this service or they can choose any participating Specialist Physician.

2. Normal Pregnancy

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

3. Complications of Pregnancy

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

4. Minimum Length of Stay

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

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

5. Interruptions of Pregnancy

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

6. Nursery Care

Ordinary nursery care of the newborn infant is covered.

7. Routine Newborn Care

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

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

Routine neonatal circumcision is covered.

M. ARTIFICIAL INSEMINATION

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

N. THERAPEUTIC DRUGS THAT ARE NOT SELF-ADMINISTRABLE

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

O. DIAGNOSTIC SERVICES-OUTPATIENT

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

1. Diagnostic radiology, consisting of x-ray, ultrasound, and nuclear medicine. Diagnostic mammograms, which are recommended by a Physician, are covered for all Participants.
2. Diagnostic laboratory and pathology tests.
3. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life.
4. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan, and nuclear cardiology studies approved by First Priority Life. The Participant may be responsible for a copayment as indicated on the Schedule of Benefits. If the diagnostic imaging procedure is rendered in conjunction with an Outpatient emergency room visit, Inpatient admission, observation status, or ambulatory surgical procedure, the Copayment per test/scan will be waived.
5. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

P. THERAPY SERVICES-OUTPATIENT

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

1. Cardiac Rehabilitation Therapy is limited to a Maximum of thirty-six (36) visits per Benefit Period or as indicated in the Schedule of Benefits.
2. Dialysis Treatment.
3. Pulmonary Rehabilitation Therapy is limited to a Maximum of eighteen (18) visits per Benefit Period or as indicated in the Schedule of Benefits.
4. Radiation Therapy, including the cost of radioactive materials.
5. Respiratory Therapy, when performed by a Professional Provider or when prescribed by a Physician and performed by a Respiratory Therapist, is limited to a Maximum of eighteen (18) visits per Benefit Period or as indicated in the Schedule of Benefits.
6. Short term therapy is Occupational, Physical, or Speech Therapy which:
 - is prescribed by a Physician,
 - is Medically Necessary to regain lost function after an accidental injury, Surgery, or an acute illness, and
 - will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

Occupational, Physical, and Speech Therapy are limited to a combined forty-five (45) visits per benefit period.

Q. MENTAL HEALTH CARE SERVICES

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

Except in an emergency, Inpatient and Partial Hospitalization Covered Services are provided when Medically Necessary and when the Community Behavioral Healthcare of Pennsylvania (CBHNP) is notified by the Participating Provider or the Participant before the Covered Services are rendered, and coordinates the Participant's care.

1. Inpatient Services

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

2. Outpatient Services

Outpatient services will be provided during a Benefit Period for Mental or Nervous Disorders and for Serious Mental Illness. Outpatient mental health care services include Outpatient professional visits and Outpatient Partial Hospitalization days.

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

Covered Services are available to a Participant who is certified by a licensed Physician or licensed Psychologist as a person who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient and Outpatient Substance Abuse treatment. Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Drug and Alcohol treatment by non-Physicians/Psychologists must be pre-certified with CBHNP before services are rendered and must meet Medical Necessity criteria.

1. Inpatient Detoxification

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

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

2. Inpatient Non-Hospital Residential Care

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

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

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

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

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

S. OXYGEN AND RELATED EQUIPMENT/SUPPLIES

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

T. SKILLED NURSING FACILITY

Covered Services are provided for care in a Participating Skilled Nursing Facility, when determined to be Medically Necessary and upon Prior Authorization by First Priority Life. Covered Services in Participating Skilled Nursing Facilities are limited to sixty (60) days per Benefit Period or as indicated in the Schedule of Benefits. The Participant must require treatment by skilled nursing personnel, which can be provided only on an Inpatient basis in a Skilled Nursing Facility. Prior Authorization procedures apply as set forth in Section CC – Care Coordination.

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

No Covered Services are payable:

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

U. HOME HEALTH CARE

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

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

1. Professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;
2. Home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
3. Physical Therapy treatments performed by a licensed Physical Therapist;
4. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;
5. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;
6. medical social service consultations when provided by a qualified medical social service worker holding a masters degree in social work;
7. Nutritional Therapy provided by a Licensed Dietitian;?
8. diagnostic and therapeutic radiology services;
9. laboratory services;
10. medical diagnostic tests and studies;
11. oxygen and Respiratory Therapy;
12. medical and surgical supplies, including bandages, ostomy supplies, dressings and casts³;and
13. the rental of Durable Medical Equipment but only on a short term basis and if not owned by the Home Health Care Agency.

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

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

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

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

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

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

No home health care Covered Services will be provided for:

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

V. HOME INFUSION THERAPY

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

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

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

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

Prior Authorization is required for all therapies when provided by Providers who are not in the First Priority Health Network. * Therapies that generally require Prior Authorization are noted with an asterisk above. Any therapy or drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be pre-approved.

Home Infusion Therapy Covered Services will not be provided for:

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

W. METABOLIC FORMULAS

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

X. HOSPICE CARE

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

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

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

Respite Care is available with a Maximum of ten (10) days per lifetime (of the 180-day lifetime Maximum) or as indicated in the Schedule of Benefits. Covered Services are payable according to the Maximums set forth in herein.

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

1. professional services of a Registered Nurse or Licensed Practical Nurse;
2. pain management;
3. Chemotherapy and/or Radiation Therapy;
4. parenteral or enteral nutrition therapy;
5. prescription drugs;
6. laboratory services;
7. dietitian services;
8. medical and surgical supplies, ostomy supplies and Durable Medical Equipment⁴;
9. oxygen and its administration;
10. medical social service consultation provided by a social worker;
11. counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
12. home health aide and homemaker services; and
13. any needed therapies.

Y. DIABETES EDUCATION/EQUIPMENT/SUPPLIES

Diabetes Education

Covered Services are provided for diabetes education services as described herein. Diabetes Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and

treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician shall include: (1) visits Medically Necessary upon the diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

Diabetic Equipment and Supplies

Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses.

Equipment and supplies prescribed as a result of diabetes as set forth in this Subsection are not subject to the Maximum set forth in Subsection Durable Medical Equipment/Prostheses/Orthoses or the Ostomy Supplies in the Description of Covered Services section.

The Participant's coverage includes Prescription Drug coverage. The Participant is responsible for the applicable Coinsurance and deductible for each Prescription. The Coinsurance and/or deductible payment, if any, is paid by the Participant directly to the Pharmacy for each Prescription.

The Covered Services provided for equipment and supplies, pharmacological agents and Orthoses for the treatment of diabetes are available under the Agreement.

Z. BLOOD AND BLOOD PLASMA

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

AA. AMBULANCE SERVICES

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

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

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

Emergency transportation provided by a licensed ambulance service shall constitute an emergency ambulance transport.

BB. PREVENTIVE CARE

Coverage will be provided for the preventive care services provided for in the Patient Protection and Affordable Care Act. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization

Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive care services include, but are not limited to the following:

1. Immunizations

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

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

2. Routine Gynecological Examinations and Pap Smears

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

3. Screening Mammograms

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

4. Colorectal Cancer Screening and Prostate Cancer Screening

Coverage for colorectal cancer screening is provided for covered individuals.

Coverage for non-symptomatic covered individuals shall include, but is not limited to:

- i. One (1) fecal occult blood test per Benefit Period.
- ii. One (1) sigmoidoscopy per Benefit Period, one (1) screening barium enema per Benefit Period or a test consistent with approved medical standards and practices to detect colon cancer.
- iii. One (1) colonoscopy at least once every ten (10) years.

Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician. Coverage for non-symptomatic covered individuals who are at high or increased risk for colorectal cancer who are under fifty (50) years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008, and consistent with approved medical standards and practices. Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Preferred Provider.

5. Prostate Cancer Screening

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

6. Preventive Drugs

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

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

7. Nutritional Therapy

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

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

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

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

CC. ALLERGY EXTRACTS/INJECTIONS

Covered Services are provided for allergy extracts and antigen injections.

DD. DURABLE MEDICAL EQUIPMENT/PROSTHESES/ORTHOSES

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

Instructions regarding appropriate use of the item are covered.

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

- a. hospital beds and related equipment (bed rails, mattresses);
- b. equipment to increase mobility (walkers, wheelchairs);
- c. commodes (elevated seats, portable bedside commodes);
- d. breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);
- e. therapeutic equipment;
- f. apnea monitors;
- g. Jobst pressure garments used in burn treatment; and
- h. Unna boots and air casts.

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

- a. artificial limbs;
- b. knee braces, not made of elastic or fabric support;
- c. splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or "figure-8", finger, Pavlik harness and wrist);
- d. immobilizers;
- e. corrective shoes, shoe inserts and supports, and/or other foot Orthoses;
- f. supportive back braces with metal stays;
- g. dynasplints; and
- h. cryocuffs.

EE. CHIROPRACTIC MANIPULATIVE COVERED SERVICES

For Participants age thirteen (13) and above, Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum per Benefit Period as set forth in the Outline of Coverage, if Medically Necessary. No coverage is provided for Participants under the age of thirteen (13). Prior Authorization is required to obtain Covered Services from Providers who are not in the FPH Network.

FF. OSTOMY SUPPLIES

Covered Ostomy Supplies include and are limited to the following:

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

Ostomy Supplies are covered as specified in Section SB – Schedule of Covered Services for Covered Medical Expenses up to a maximum of \$1,000 per Insured per Benefit Period. Coverage is limited to supplies obtained from Participating Providers.

Supplies prescribed as a result of diabetes pursuant to Subsection Y, Diabetes Education/Equipment/Supplies of this Description of Covered Services Section are excluded from this Covered Service.

Ostomy Supplies provided to a Participant pursuant to Subsection U, Home Health Care or pursuant to Subsection X, Hospice Care will not reduce this Covered Service.

GG. AUTISM SPECTRUM DISORDERS

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

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

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

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

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

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

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

following Calendar Year. The Autism Spectrum Disorder Maximum shall be adjusted effective January 1 of the following Calendar Year.

The Outline of Coverage specifies whether Prescription Drug coverage applies.

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

HH. RETAIL CLINIC CARE

Covered Services are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient. Covered Services are provided for the examination, diagnosis, and treatment of common minor ailments. A primary care office visit copayment applies per visit.

II. EXPERIMENTAL OR INVESTIGATIVE SERVICES

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

1. If, in making that determination, a Medical Director of First Priority Health finds that the Services, 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 on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative.

2. If, in making that determination, a Medical Director of First Priority Health finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then a Medical Director of First Priority Health may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:

- a. the technology must have final approval from the appropriate governmental regulatory bodies;
- b. the scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- c. the technology must improve the net health outcome;
- d. the technology must be as beneficial as any established alternatives; and
- e. the improvement must be attainable outside the investigational settings.

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

3. If, in making the determination, a Medical Director of First Priority Health finds that a drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is rendered; (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.

MEDICAL EXCLUSIONS AND LIMITATIONS

This Plan will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies:

1. Services, which are not Medically Necessary, except those that are provided within the policy for preventive services or those mandated by law.
2. Any service in connection with or required by a procedure not set forth in the foregoing Description of Covered Services Section, except as necessitated by subsequent complications.
3. Services in excess of any Benefit Maximum as stated.
4. Charges for services or supplies incurred prior to the Participant's Effective Date.
5. Except as provided by the Plan, charges for services or supplies incurred after the date of termination of the participant's coverage.
6. Charges, which exceed the Allowable Charge.
7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.
8. All non-Emergency Services rendered in or performed by a Non-Participating Provider without Prior Authorization from First Priority Health prior to services being rendered.
9. Services which are not prescribed, performed or directed by a Provider licensed to do so.
10. Services which First Priority Health initially determines are Experimental or Investigative and the Covered Services related to them; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative.
11. Payment for any Covered Services as secondary carrier, unless the required Prior Authorizations are obtained.
12. Coverage for a Participant who is on active military duty or for services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country, when the Participant is legally entitled to other coverage and facilities are reasonable available to the Participant.
13. Treatment or services received as a result of a Participant's participation in a riot or insurrection.
14. Services as a result of injuries sustained during a Participant's commission of or attempt to commit a felony.
15. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from Surgery.
16. The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy; otoplasty; rhytidectomy; blepharoplasty; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following a Mastectomy; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry

following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.

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

18. With respect to the extraction of partially or totally bony impacted wisdom teeth:

- Hospital or Ambulatory Surgical Facility services are not covered, except for if authorized by a Medical Director of First Priority Health as set forth in Section DB – Description of Covered Services, Surgery, Paragraph 3.
- General anesthesia charges are not covered, except if authorized by a Medical Director of First Priority Health as set forth in Section DB – Description of Covered Services, Surgery, Paragraph 3.

With respect to all other dental procedures and oral Surgery, the following are excluded:

- Removal of natural teeth, except when it is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations.
- All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injuries to the jaws, sound natural teeth, mouth or face. Chewing or biting shall not be considered an accidental injury.
- Dental appliances including, but not limited to dentures or bridges, except for the primary restoration following facial/dental trauma or when an integral part of a cleft palate repair.
- Dental implants.
- Treatment of diseases of the teeth or gums, including, but not limited to treatment of dental cavities.
- Periodontics, endodontics, and orthognathic Surgery.
- Orthodontics, except orthodontic treatment related to cleft palate repair as described in Subsection F. Surgery of the Description of Covered Services Section.
- Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.
- Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures unless such procedures were for the treatment of accidental bodily injury.

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

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

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

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

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

24. Adult circumcision in the absence of disease.

25. Reversal of voluntary sterilization.

26. Charges in connection with penile implants.
27. 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.
28. The purchase of organs which are sold rather than donated to transplant recipients, transplants involving mechanical organs or non-human organs and charges for organ donor searches are also excluded from coverage.
29. Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.
30. Corneal surgery to change the shape of the cornea to correct vision problems, except for accidental injury or medically necessary conditions resulting from corneal surgery.
31. Except as provided in Section DB – Description of Covered Services, Subsection A, Primary Care Physicians and Specialist Physicians: routine eye examinations, refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.
32. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.
33. Physical, psychiatric or psychological examinations, testing, reports, or treatments, when such services are: (a.) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (b.) relating to judicial or administrative proceedings or orders; (c.) conducted for purposes of medical research; or (d.) to obtain or maintain a license of any type.
34. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to, allergen filtration systems including allergy products.
35. Provision or replacement of the following items, including, but not limited to:
(a) deluxe equipment of any sort or equipment which has been otherwise determined by the Plan to be non-standard;
(b) items, which are primarily for personal comfort or convenience, including, but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, or prosthetic socks, except when administered by a home health agency as part of the home health benefit or as provided in the Description of Covered Services, Subsection Y, Diabetes Education/Equipment/Supplies or Subsection GG, Ostomy Supplies; (d) exercise equipment; (e) self-help devices including, but not limited to: elevators, lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or piece of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, unless as specifically provided in Section DB – Description of Covered Services, Subsection A, Primary Care Physicians and Participating Specialist Physicians; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) pro-glide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; (v) modification or customization of any Durable Medical Equipment.
36. Examinations for the prescription, fitting or adjustment of hearing aids.
37. Charges for telephone calls or consultations, except telephone calls or consultations provided by a Primary Care Physician; failure to keep a scheduled visit; completion of forms, transfer or copying of records or generation of correspondence.
38. Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in the Description of Covered Services.

39. Charges for a private room when a Semi-Private Room is available.
40. Inpatient services that could safely and adequately be performed in a home, Provider's office or at any other level of institutional care.
41. Long-Term Residential Care.
42. Custodial care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.
43. Outpatient cognitive rehabilitation services which have been determined by First Priority Health not to be Medically Necessary and appropriate for the treatment of brain injury.
44. Pulmonary rehabilitative therapy on an Inpatient basis.
45. Therapy and devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.
46. Take-home drugs, both prescription and non-prescription, dispensed by a Facility Provider or Professional Provider; contraceptive drugs and devices and fertility drugs regardless of use; drugs in certain drug classes specifically designated by the Plan as Specialty Drugs including, but not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech drugs; except those drugs administered by a Participating Professional Provider that are not self-administrable and/or that are provided incident to a Covered Service; those drugs that are mandated to be covered by law; and/or which are covered under Section Rx – Prescription Drug Coverage, when coverage is provided for Prescription Drugs. (The Outline of Coverage specify whether Prescription Drug coverage applies.)
47. Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except those drugs that are mandated to be covered by law; and/or those providing at least thirty-five (35) percent of daily caloric requirements given enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take nutrition by mouth, or in conditions of gastrointestinal tract impairment, parenterally through an intravenous catheter. Infant formulas including those prescribed for reasons of fat malabsorption, lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic formulas except those that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
48. · Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD under the Agreement and for Participants age twenty-one (21) and over.
 - Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in the Description of Covered Services.
 - Treatment of Autism Spectrum Disorder through the use of Chelation Therapy.
 - Any services listed in an Individual Education Plan (IEP) are not covered.
49. Services for the treatment of anti-social personality, conduct disorders and paraphilias.
50. Substance Abuse services utilizing methadone or methadone-like equivalents.
51. Biofeedback/neurofeedback.
52. Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures unless covered under the Description of Covered Services Section.
53. Charges to the extent payment has been made under Medicare or when Medicare is the primary carrier, or under another governmental program, except Medicaid.

54. Charges to the extent payment has been made under a state or federal workers' compensation, employer's liability or occupational disease law, or local government program.
55. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law or any applicable federal or state law. This exclusion applies regardless of whether the Participant claims the benefit compensation.
56. Alternative and complementary medicine, except as provided in Section CC – Care Coordination, Subsection D, Case Management.
57. Services performed by a Provider with the same legal residence as a Participant or who is a family member, including but not limited to: spouse, brother, sister, parent or child.
58. Services of Immediate Family or persons of the Participant's household.
59. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay and for which no charge would have been made in the absence of insurance.
60. Unattended Services.
61. Separate charges by interns, residents and other health care professionals who do not have a Participating Provider Agreement with First Priority Health, who are directly, or indirectly, employed by a Hospital or Facility Other Provider which is a Participating Facility Provider with First Priority Health and makes their services available.
62. Educational classes, support groups and disease management programs unless sponsored or provided by the Plan, except as required for diabetes education services
63. Copayments, Deductibles, Coinsurance, or penalties applied under the Agreement

CARE COORDINATION

A. MEDICAL NECESSITY

Participants will receive Covered Services under this Agreement only when Medically Necessary. Medical Necessity for Covered Services will be determined prior to the service being rendered when Prior Authorization is required. First Priority Health may determine whether any Covered Service provided under the Agreement was Medically Necessary, and the Participant along with his/her Primary Care Physician has the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to Medical Necessity are subject to review by a Medical Director of First Priority Health or his/her Physician designee. First Priority Health will not, however, seek reimbursement from a Participant for the cost of any Covered Service provided under the Agreement that is later determined not to have been Medically Necessary, provided that the Participant was not notified prior to the provision of such Covered Service that such Covered Service would not be Medically Necessary. If a Participant has a concern about a service being covered, he/she should contact First Priority Health by calling a BlueCare Service Representative prior to the service being rendered. The Participant shall have the right to appeal such determinations as set forth by the Plan.

B. PRIOR AUTHORIZATION

If a Participant has a concern regarding whether Prior Authorization is required, he/she should contact First Priority Health by calling a BlueCare Service Representative prior to the service being rendered. Additionally, the Participant is responsible to confirm with a BlueCare Service Representative that their Provider obtained Prior Authorization prior to the service being rendered.

- Maternity admissions to participating Hospitals do not require Prior Authorization. However, Prior Authorization is required for maternity admissions to Hospitals which do not participate in the FPH Network of Providers.

- With the exception of maternity admissions to Hospitals participating in the First Priority Health Network and Outpatient Emergency Services, Prior Authorization is required before all other Inpatient admissions in a Hospital, Skilled Nursing Facility, Rehabilitation Hospital or Psychiatric Hospital, regardless of Provider.
 - For Inpatient emergency admission to a Participating Provider, the Provider is responsible for notifying First Priority Health within forty-eight (48) hours of the emergency admission or as soon as reasonably possible. For all other Inpatient emergency admissions, the Participant is responsible for notifying the First Priority Health within forty-eight (48) hours of the emergency admission or as soon as reasonably possible.
 - For Outpatient Emergency Services, if the Primary Care Physician advises the Participant to seek care at the Hospital emergency room and the services could have been rendered in his/her office, the Primary Care Physician is required to notify First Priority Health of his/her authorization for the emergency room care within five (5) days of the date of service. However, if the Primary Care Physician advises the Participant to seek care in the Hospital emergency room for services that could not be provided in his/her office, the Primary Care Physician is not required to submit authorization.
 - Services of certain Participating Providers and all other Providers, related to observation status require Prior Authorization.
 - Certain procedures/surgeries performed in an acute-care Hospital's short procedure unit or a freestanding surgical facility, certain diagnostic tests/scans, and home health care services require Prior Authorization, regardless of the Provider.
- Prior Authorization is required for a Participant to receive Covered Services from all Providers who are not part of the First Priority Health Network of Providers, except in the case of Outpatient Emergency Services. Prior Authorization for Covered Services from Providers outside of the FPH Network will only be granted when:
- First Priority Health determines prior to the service being rendered that the service is Medically Necessary; and
 - First Priority Health does not have in its network a Participating Provider who can provide the needed service.

Non-Participating Providers are not obligated to accept First Priority Health's determination, and therefore, may bill the Participant for services. The Participant can avoid this responsibility by choosing a Participating Provider. If a Participant circumvents the Primary Care Physician or participating Specialist Physician and obtains services from a Provider outside of the First Priority Health Network of Providers without the required Prior Authorizations, the Participant will be responsible for the full cost of any services rendered. Participating Providers should obtain the authorizations on behalf of Participant prior to services being rendered. First Priority Health may add or delete services and procedures, which require Prior Authorization, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan and the Participant at the address on the records of First Priority Health at least thirty (30) days in advance of such change.

Payment for prior authorized non-participating services will be subject to the applicable limitations, exclusions, and conditions of the Agreement. If the Participant's Primary Care Physician or participating Specialist Physician believes that the Participant needs to see a Physician or other Provider who does not participate with First Priority Health, then the Participant's Primary Care Physician or participating Specialist Physician must submit medical information telephonically or in writing to First Priority Health. First Priority Health's medical staff will review the information and will notify the Participant's Primary Care Physician or participating Specialist Physician of the decision. Authorizations for visits to Providers who are not part of the First Priority Health Network of Providers are approved only when Medically Necessary and when First Priority Health does not have in its network a Participating Provider who can provide the needed service. When a Participating Provider in the First Priority Health Network cannot render the service, the Participant along with his/her Primary Care Physician and First Priority Health will determine where the service can be performed in order for coverage to be provided. Only those visits made after approval is given are covered. If the Participant's Primary Care Physician or participating Specialist Physician is not available, another Participant of his or her group can assist the Participant in obtaining an authorization from First Priority Health.

The following guidelines must be followed:

1. Before seeing any Provider who is not in the FPH Network, even if the Participant is under the Physician's care prior to enrolling in First Priority Health, it will be necessary to obtain First Priority Health's approval prior to services being received. The Participant's Primary Care Physician or participating Specialist Physician must submit in writing, medical information to First Priority Health to request the authorization on behalf of the Participant.
 2. Authorization for visits to Providers who are not in the FPH Network will be granted for a specified condition and are assigned a specific number of visits. If the services rendered are different from the services authorized, those services will not be covered by First Priority Health.
 3. All authorizations to receive services from Providers not in the FPH Network will be assigned an expiration date that is one hundred and eighty (180) calendar days from the date the authorization is given. If the Participant is unable to schedule an appointment with the Provider within this one hundred and eighty (180)-day period, or if additional visits are necessary following the expiration of this one hundred and eighty (180)-day period, the Participant must contact the Primary Care Physician or participating Specialist Physician who initiated the authorization to request that he/she contact First Priority Health to obtain approval to have the number of visits increased or extended.
 4. If the Participant is unsure whether or not the Primary Care Physician or participating Specialist Physician's office has obtained an authorization or if it is necessary to verify the number of unused visits or the expiration date, the Participant may call First Priority Health to speak with a BlueCare Service Representative for assistance at the number located on the Participant's identification card. If a Participant per circumvents the Primary Care Physician or participating Specialist Physician and obtains services from a Provider outside of the FPH Network of Providers without the required Prior Authorizations, the Participant will be liable for the full cost of any services rendered. Failure to obtain Prior Authorization before services are rendered will result in a denial of Covered Services.
- _ When a Participant circumvents the Primary Care Physician or the participating Specialist Physician and obtains services from a Provider outside of the FPH Network of Providers without the required Prior Authorizations, the Participant will be responsible for the full cost of the services, even if it is determined that the services were Medically Necessary.
- _ Participating Providers are responsible for obtaining the Prior Authorization on behalf of a Participant. If the Participating Provider fails to obtain the necessary Prior Authorization before the service is provided, the Participating Provider will be responsible for the full cost of the services and First Priority Health will hold the Participant harmless from any financial obligation other than the applicable Deductible, Coinsurance, Copayment amounts, or amounts in excess of any Benefit Maximum.

C. CONCURRENT REVIEW

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

D. CASE MANAGEMENT

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

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

If First Priority Health elects to provide alternative Covered Services for a Participant in one instance, it shall not

obligate First Priority Health to provide the same or similar Covered Services for any Participant in any other instance, nor shall it be construed as a waiver of First Priority Health's right to administer the Agreement thereafter in strict accordance with its express terms.

PRESCRIPTION DRUG BENEFIT

DEFINITIONS—PRESCRIPTION DRUG SERVICES

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

COVERED PHARMACY EXPENSE – A service or supply specified in the Plan for which Covered Services for Prescription Drugs and supplies will be provided pursuant to the terms of the Plan.

DRUG FORMULARY – A listing of Preferred Prescription Drugs and supplies covered by First Priority Life, which is subject to periodic review and modification at least annually by a committee of appropriate actively practicing preferred Physicians and Pharmacists. Prescription Drug inclusions in the Drug Formulary are based on a combination of criteria including clinical quality and cost effectiveness. The Drug Formulary is available upon request from Express Scripts Service Representatives by calling toll-free 1-877-603-8399 or via the website, www.bcnepa.com.

GENERIC EQUIVALENT PRESCRIPTION DRUG (Generic Equivalent Drug) – Any Prescription Drug that is considered to be therapeutically equivalent to other pharmaceutical equivalent products by the Food and Drug Administration, has received an “A Code” in the FDA “Approved Drug Products with Therapeutic Equivalence Evaluations,” and is in compliance with applicable state generic substitution laws and regulations.

MAINTENANCE PRESCRIPTION DRUG – Any Prescription Drug, not including Specialty Injectable Drugs, which First Priority Health makes available through a Participating Mail Order Pharmacy, which is generally used to treat chronic medical conditions and is generally not needed urgently for an immediate acute illness and which the Participant chooses to obtain, or First Priority Health requires be obtained, from a Participating Mail Order Pharmacy. First Priority Health may specify certain Prescription Drugs that are not available through a Participating Mail Order Pharmacy.

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

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

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

PARTICIPATING PHARMACY PROVIDER – Any Pharmacy, which has entered into a Participating Pharmacy agreement with First Priority Health or other entity contracted by First Priority Health to furnish a Pharmacy Provider network. Participating Pharmacy Providers include: Participating Community Pharmacy Providers, Participating Mail Order Pharmacy Providers and Participating Pharmacy Providers for Specialty Drugs.

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

PHARMACIST – An individual who has been issued a license by the appropriate state licensing agency to engage in the practice of pharmacy, including the preparation and dispensing of Prescription Drugs and the dissemination of drug information to patients and health professionals.

PHARMACY – An establishment which has been issued a permit by the appropriate state licensing agency wherein the practice of pharmacy is conducted under the direct supervision and control of a licensed Pharmacist.

PREFERRED PRESCRIPTION DRUG – Any Prescription Drug, which is listed in the Drug Formulary and preferred by First Priority Life. Preferred Prescription Drugs are those listed in Tier 0, Tier 1 or Tier 2 of the Drug Formulary.

PRESCRIBER – An individual who has been issued a license by the appropriate state licensing agency to engage in a health care professional practice, who, acting within the scope of his/her license, is duly authorized by law to prescribe Prescription Drugs.

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

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

PRESCRIPTION DRUG COINSURANCE – The specific percentage of Covered Pharmacy expenses for which the Participant is responsible as set forth in the Outline of Coverage and in the Subsection B, Schedule for Covered Pharmacy Expenses.

PRESCRIPTION DRUG COINSURANCE MAXIMUM – A specified dollar amount of Coinsurance that applies to Covered Pharmacy Expenses incurred by a Participant in a Benefit Period,

PRESCRIPTION DRUG COPAYMENT – The amount a Participant must pay directly to Pharmacy Providers in connection with Covered Services set forth on the Schedule of Benefits.

PRESCRIPTION DRUG DEDUCTIBLE – A specified amount of Covered Pharmacy Expenses, usually expressed in dollars that must be incurred by a Participant before First Priority Health and the Plan will assume any liability for all or part of the remaining Covered Pharmacy Expenses.

PRESCRIPTION DRUG MAXIMUM – The greatest Covered Service amount payable for covered Prescription Drugs.

PRIOR AUTHORIZATION – With regard to Prescription Drug Covered Services, Prior Authorization means the process whereby the Prescriber and/or the Participant is given prior approval by First Priority Health for certain Prescription Drugs, including Drug Formulary exceptions, and utilization review criteria, which have been designated by First Priority Health as requiring Prior Authorization.

SPECIALTY DRUG – Any Prescription Drug, which has been specifically designated by First Priority Health as being available from only a Participating Pharmacy for Specialty Drugs. Such Prescription Drugs classes include, but are not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech drugs. From time-to-time, such as when new biotech drugs become available, First Priority Health may specify certain Prescription Drugs that are available from only a Participating Pharmacy for Specialty Drugs.

SCHEDULE FOR COVERED PHARMACY EXPENSES

Except for special circumstances described in the Prescription Drugs with Mail Order section, Prescription Drugs dispensed by a non-participating Pharmacy are not covered. Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified on the Schedule of Benefits for one of the three options outlined below. Reimbursement will not exceed that set for the Generic Equivalent Drug.

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

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

or

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

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

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

Unless indicated otherwise on the Outline of Coverage, if the Participant's coverage does not include Prescription Drug coverage for each Prescription prescribed for the treatment of Autism Spectrum Disorder, there is a \$0 Tier 0, \$15 Tier 1, \$30 Tier 2, and \$50 Tier 3 Prescription Drug Copayment payable by the Participant directly to the Participating Pharmacy for each Prescription; there is a \$0 Tier 0, \$30 Tier 1, \$70 Tier 2, and \$150 Tier 3 mail order Prescription Drug Copayment payable by the Participant directly to the Participating Mail Order Pharmacy Provider.

PRESCRIPTION DRUGS WITH MAIL ORDER

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

- Covered drugs/supplies include: (a) Prescription Drugs which can be self-administered, including contraceptives for the use of birth control, if so specified on the Schedule of Benefits, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, sensors, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other drugs/supplies which may be specifically designated by First Priority Life, and (i) the covered pharmaceutical services necessary to make such drugs available, not including, however, any drug or group of drugs specifically excluded by the terms of the Plan.
 - (a.) Each Prescription Drug is limited to a thirty (30) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature, and/or quantity limits allowed by First Priority Life.
 - (b.) Each Maintenance Prescription Drug is limited to a ninety (90) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature, and/or quantity limits allowed by First Priority Life.

- 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.
- Unless the Prescriber or Pharmacist has requested and received Prior Authorization for an early refill, the claim will be denied if a refill is requested before the time seventy-five (75) percent of the days' supply of medication has passed. An early refill Prior Authorization can be granted for an additional supply for reasons such as vacation or business travel. A Participating Pharmacy may receive authorization by telephone to fill the prescription early on a one-time-only basis any time before the next regular refill due date.
- In order to receive Covered Services, the Participant must present the First Priority Health Identification Card to a Participating Pharmacy and the claim must be filed by a Participating Pharmacy, except in special circumstances and such other situations as deemed appropriate by the Plan. In special circumstances, such as when a Participant needs an unexpected Prescription when beyond a reasonable distance from a Participating Pharmacy, while vacationing or traveling out-of-area, inaccessibility to a Participating Pharmacy, inaccessibility of the First Priority Health electronic claims/eligibility systems, or for urgent or emergency needs, the Participant may request reimbursement for purchased Prescriptions from the Plan. Reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for the Generic Equivalent Drug, less the Copayment. If there is no Generic Equivalent Drug, reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for a Preferred Prescription Drug, less the Copayment. Such requests are subject to a filing limit of one (1) year from the date of purchase.
- All Prescription Drug claims are subject to prospective, concurrent and/or retrospective drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. Before prescribing the Prescription Drug, a Participating Prescriber will advise the Participants if Prior Authorization is required and request the Prior Authorization on behalf of the Participant. Participating Prescribers must accept the Plan's initial determination of Medical Necessity. In the event the Prior Authorization is denied for lack of Medical Necessity, no Covered Services will be provided by the Plan when the Participants disregard the Prior Authorization denial and elects to purchase the Prescription Drug. Should a Prescription Drug, which requires Prior Authorization, be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant prospectively that the claim was denied by the Plan because Prior Authorization is required for coverage of the Prescription Drug.

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

PRESCRIPTION DRUG EXCLUSIONS

Prescription Drug exclusions follow.

- Charges for any Prescription Drug or supply, which is not Medically Necessary and appropriate based on one (1) or more of the following reasons:
 - The indication and/or use is of a cosmetic nature or to enhance physical appearance; to enhance athletic performance; or for weight loss.
 - Based on the Pharmacist's professional judgment, the Prescription should not be dispensed.
 - The Prescription Drug or supply is subject to Prior Authorization and has not been authorized as an exception, (based on, and supported by, medical justification from the Prescriber) for the following reason:
 - The use of the Prescription Drug or supply is contraindicated due to: overutilization, drug-drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, or drug allergy.
 - The use of the Prescription Drug or supply is subject by First Priority Health to utilization review criteria.

- The Schedule of Benefits indicates whether oral contraceptives are covered. If oral contraceptives are not covered, coverage will not be provided for any Prescription Drug or supply being used for the prevention of pregnancy, including all dosage forms of contraceptives, except when used for an approved medical condition.
- Charges for any Prescription Drug or supply, unless authorized in the Plan, which are:
 - Experimental or Investigative.
 - Not approved for use by the Food and Drug Administration.
 - Not approved for the specific indication by the Food and Drug Administration.
- Unless specifically included in the Description of Covered Services, the following are excluded as Covered Pharmacy Expenses:
 - drugs which do not require a Prescription; (2.) drugs which cannot be self-administered; (3.) medical supplies; devices and equipment, (4.) test agents and devices, except those used for diabetes; (5.) smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by First Priority Health which are covered for one treatment period per lifetime; (6.) multiple vitamins, except those used for pregnancy and multiple vitamins with fluoride for the prevention of dental caries in children under the age of sixteen (16); (7.) injectable drugs used to treat infertility; (8.) drugs for impotence in excess of four doses per month; (9.) allergy extracts for allergen immunotherapy; (10.) administration or injection of any drugs; (11.) replacement of lost, stolen or damaged drugs; (12.) take home drugs dispensed by a Facility Provider or Professional Provider.

TERMINATION OF COVERAGE

When does my participation end?

Your participation will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The last day of the month for which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The last day of the month in which you cease to be eligible for coverage under the *Plan*;
- The last day of the month in which you terminate employment; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for my dependents?

The coverage for your *dependents* will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The last date of the month in which the *Plan* discontinues coverage for *dependents*;
- The last date of the month in which your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your *dependents*;

- In the case of a *child* for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month in which earliest of the following events occurs:
 - Cessation of the inability;
 - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
 - Upon the *child's* no longer being *dependent* on you for his support;
- In the case of a *child* other than a *child* for whom coverage is continued due to mental or physical inability to earn his own living, the last date of the month on which the *child* reaches age 26;
- The last date of the month in which person ceases to be a *dependent*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

Will the *Plan* provide evidence of coverage?

The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan*. In addition, a *certificate of coverage* will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

Will my *participating employer* continue our coverage?

Coverage will be continued for you and your *dependents* should the following occur:

- In the event of a layoff, coverage will continue until the last day of the month following the date of layoff;
- In the event of *total disability*, coverage will continue until the last day of the month following termination of *active employment*; or
- In the event you take a *leave of absence* which does not meet the requirements of *FMLA*, your coverage will continue for up to 140 days.

The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA.

May I continue participation during *FMLA leave*?

The Family and Medical Leave Act is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible *employee* may elect to continue coverage under this *Plan* during a period of approved *FMLA leave* at the same cost as if the *FMLA leave* not been taken.

If provisions under the *Plan* change while you are on *FMLA leave*, the changes will be effective for you on the same date as they would have been had you not taken leave.

Am I an eligible *employee*?

You are an eligible *employee* if all of the following conditions are met:

- You have been employed with the *participating employer* for at least 12 months;

- You have been employed with the *participating employer* at least 1,250 hours during the 12 consecutive months prior to the request for *FMLA leave*; and
- You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

What circumstances qualify for *FMLA leave*?

Coverage under *FMLA leave* is limited to a total of 12 workweeks during any 12-month period that follows:

- The birth of, and to care for, your *son or daughter*;
- The placement of a *child* with you for adoption or foster care;
- Your taking leave to care for your *spouse, son or daughter, or parent* who has a *serious health condition*; or
- Your taking leave due to a *serious health condition* which makes you unable to perform the functions of your position.
- A *qualifying exigency* arising out of the fact that a *spouse, son or daughter, parent, or next of kin* of the *employee* is a regular or reserve component in the Armed Forces.

Coverage under *FMLA leave* is limited to a total of 26 workweeks during any 12-month period for the following situations:

- To care for a service member following a *serious illness or injury* to that service member, when the *employee* is that service member's *spouse, son or daughter, parent, or next of kin*.
- To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a *serious illness or injury* that occurred any time during the five years preceding the date of treatment, when the *employee* is that veteran's *spouse, son or daughter, parent, or next of kin*.

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your *participating employer* has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the *Plan* contribution, if any, during the *FMLA leave*. Payment must be made within 30 days of the due date established by the *Plan Administrator*. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

What are the notice requirements for *FMLA leave*?

You must provide at least 30 days' notice to your *participating employer* prior to beginning any leave under *FMLA*. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your *participating employer* has the right to require medical certification to support your request for leave due to a *serious health condition* for yourself or your eligible family members.

How long may I take *FMLA leave*?

During any one 12-month period, the maximum amount of *FMLA leave* may not exceed 12 workweeks for most *FMLA* related situations. The maximum periods for an *employee* who is the primary care giver of a service member with a *serious illness or injury* that was *incurred* in the line of active duty may take up to 26 weeks of *FMLA leave* in a single 12-month period to care for that service member. Your *participating employer* may use any of four methods for determining this 12-month period.

If you and your *spouse* are both employed by the *participating employer*, *FMLA leave* may be limited to a combined period of 12 workweeks, for both *spouses*, when *FMLA leave* is due to:

- The birth or placement for adoption or foster care of a *child*; or

- The need to care for a *parent* who has a *serious health condition*.

Will FMLA leave terminate before the maximum leave period?

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

- When you inform your *participating employer* of your intent not to return from leave;
- When your employment relationship would have terminated but for the leave (such as during a reduction in force);
- When you fail to return from the leave; or
- If any required *Plan* contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under *FMLA leave* ends, you will be eligible for *COBRA* continuation of coverage at that time.

Recovery of Plan contributions

Your *participating employer* has the right to recover the portion of the *Plan* contributions it paid to maintain coverage under the *Plan* during an unpaid *FMLA leave* if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a *serious health condition* that entitles you to *FMLA leave* (in which case your *participating employer* may require medical certification) or other circumstances beyond your control.

Will my coverage be reinstated when I return to work?

The law requires that coverage be reinstated upon your return to work following an *FMLA leave* whether or not you maintained coverage under the *Plan* during the *FMLA leave*.

On reinstatement, all provisions and limits of the *Plan* will apply as they would have applied if *FMLA leave* had not been taken. The *waiting period* will be credited as if you had been continually covered under the *Plan*.

Definitions

For this provision only, the following terms are defined as stated.

Next of kin the nearest blood relative to the service member.

Parent is your biological parent or someone who has acted as your parent in place of your biological parent when you were a *son* or *daughter*.

Qualifying exigency includes the following situations:

- Short-notice deployment.
 - To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
 - Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
- Military events and related activities.
 - To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and

- To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
- Childcare and school activities.
 - To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster *child*, a stepchild, or a legal ward of a covered military member, or a *child* for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence;
 - To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster *child*, a stepchild, or a legal ward of a covered military member, or a *child* for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence;
 - To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
 - To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;
- Financial and legal arrangements.
 - To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and
 - To act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;
- Counseling. To attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster *child*, a stepchild, or a legal ward of the covered military member, or a *child* for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that *FMLA leave* is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

- Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible *employees* may take up to five days of leave for each instance of rest and recuperation;
- Post-deployment activities.
 - To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
 - To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and
- Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the *participating employer* and *employee* agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

Serious health condition is an *illness, injury*, impairment, or physical or mental condition that involves:

- Inpatient care in a *hospital*, hospice, or residential medical facility; or
- Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or *surgery*, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

Serious illness or injury is defined as an *illness or injury incurred* in the line of duty that may render the service member medically unfit to perform his or her military duties.

Son or Daughter is your biological, child, adopted child, stepchild, foster child, a child placed in your legal custody, or a child for which you are acting as the parent in place of the child's natural blood related parent.

Spouse is your husband or wife.

NOTE: For complete information regarding your rights under *FMLA*, contact your *participating employer*.

May I continue participation while I am absent under *USERRA*?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("*USERRA*") is a federal law, under which you may elect to continue coverage under the *Plan* for yourself and your *dependents*, where:

- They were *covered persons* in the *Plan* immediately prior to your leave of absence for *uniformed service*; and
- The reason for your leave of absence is due to active service in the *uniformed services*.

In addition, you must meet the following requirements:

- You (or an appropriate officer of the *uniformed service*) must give advance written or verbal notice of your service to your *participating employer*. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;
- The cumulative length of this absence and all previous absences with your *participating employer* by reason of your service in the *uniformed service* does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

- You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your *participating employer* to allow you to elect coverage which is identical to similarly situated employees who are not on *USERRA* leave. This means that if the coverage for similarly situated *employees* and *dependents* is modified, coverage for the individual on *USERRA* leave will be modified.

What is the cost of continuing coverage under *USERRA*?

The cost of continuing your coverage will be:

- For leaves of 30 days or less, the same as the contribution required from similarly situated *employees*;
- For leaves of 31 days or more, up to 102% of the contribution required from similarly situated *employees* and your *participating employer*.

Continuation applies to all coverage provided under this *Plan*, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through *USERRA* terminate?

Continued coverage under this provision will terminate on the earliest of the following events:

- The date you fail to apply for, or return to, work for your *participating employer* following completion of your leave. You must notify your *participating employer* of your intent to return to employment within:
 - For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the *uniformed service*, by reporting to the *participating employer*:
 - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
 - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.
 - For leaves of 30 to 180 days, by submitting an application for reemployment with your *participating employer*:
 - Not later than 14 days after completing *uniformed service*; or
 - If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.
 - For leaves of more than 180 days, by submitting an application for reemployment with your *participating employer* not later than 90 days after completing *uniformed service*.
 - If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the *uniformed service*, by reporting to, or submitting an application for reemployment with, your *participating employer* (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your *participating employer* impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.
- The date you fail to pay any required contribution.

- For elections before December 10, 2004, 18 months from the date your leave began.
- For elections on or after December 10, 2004, 24 months from the date your leave began.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under *COBRA*.

How will my coverage be reinstated on return from *USERRA* leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your *dependents'* coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under *USERRA*?" and, if your absence was more than 30 days, you have furnished any available documents requested by your *participating employer* to establish that you are entitled to the protections offered by *USERRA*. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your *dependents'* coverage) not terminated as a result of your service in the *uniformed service*. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the *uniformed services*.

NOTE: For complete information regarding your rights under *USERRA*, contact your *participating employer*.

COBRA Continuation Coverage

The right to *COBRA continuation coverage* was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("*COBRA*"). *COBRA continuation coverage* can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the *Plan* when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your *dependents* fail to make timely payment of premiums. You should check with your *participating employer* to see if *COBRA* applies to you and your *dependents*.

What is *COBRA continuation coverage*?

"*COBRA continuation coverage*" is a continuation of *Plan* coverage when coverage otherwise would end because of a life event known as a "*qualifying event*." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer's* plan) are not considered for continuation under *COBRA*.

What is a *Qualifying Event*?

Specific *qualifying events* are listed below. After a *qualifying event*, *COBRA continuation coverage* must be offered to each person who is a "*qualified beneficiary*." You, your spouse, and your *dependent children* could become *qualified beneficiaries* if coverage under the *Plan* is lost because of the *qualifying event*.

If you are a *covered employee* (meaning that you are an employee and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because either one of the following *qualifying events* happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a *covered employee*, you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because any of the following *qualifying events* happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to *Medicare* benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying events* happens:

- The *parent-covered employee* dies;
- The *parent-covered employee's* hours of employment are reduced;
- The *parent-covered employee's* employment ends for any reason other than his or her gross misconduct;
- The *parent-covered employee* becomes entitled to *Medicare* benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "*dependent child*."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a *qualifying event*. If a proceeding in bankruptcy is filed with respect to Wilkes University, and that bankruptcy results in the loss of coverage of any retired employee covered under the *Plan*, the retired employee will become a *qualified beneficiary* with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become *qualified beneficiaries* if bankruptcy results in the loss of their coverage under the *Plan*.

The participating employer must give notice of some *qualifying events*

When the *qualifying event* is the end of employment, reduction of hours of employment, death of the *covered employee*, commencement of a proceeding in bankruptcy with respect to the employer, or the *covered employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *participating employer* must notify the *Plan Administrator* of the *qualifying event*.

You must give notice of some *qualifying events*

Each *covered employee* or *qualified beneficiary* is responsible for providing the *Plan Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a *qualifying event* that is a divorce of a *covered employee* (or former employee) from his or her spouse;
- Notice of the occurrence of a *qualifying event* that is an individual's ceasing to be eligible as a *dependent* under the terms of the *Plan*;
- Notice of the occurrence of a second *qualifying event* after a *qualified beneficiary* has become entitled to *COBRA continuation coverage* with a maximum duration of 18 (or 29) months;
- Notice that a *qualified beneficiary* entitled to receive *COBRA continuation coverage* with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of *COBRA continuation coverage*; and

- Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The *Plan Administrator* is:

First Priority Health
19 North Main St.
Wilkes-Barre, PA 18711
Phone (888) 338-2211

A form of notice is available, free of charge, from the *Plan Administrator* and must be used when providing the notice.

What is the deadline for providing the notice?

For *qualifying events* described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

In any event, this notice must be furnished before the end of the first 18 months of *COBRA continuation coverage*.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

The notice must be postmarked (if mailed), or received by the *Plan Administrator* (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend *COBRA continuation coverage* is lost, and if you are electing *COBRA continuation coverage*, your coverage under the *Plan* will terminate on the last

date for which you are eligible under the terms of the *Plan*, or if you are extending *COBRA continuation coverage*, such coverage will end on the last day of the initial 18-month *COBRA continuation coverage* period.

Who can provide the notice?

Any individual who is the *covered employee* (or former employee), a *qualified beneficiary* with respect to the *qualifying event*, or any representative acting on behalf of the *covered employee* (or former employee) or *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the *qualifying event*.

What are the required contents of the notice?

The notice must contain the following information:

- Name and address of the *covered employee* or former employee;
- If you already are receiving *COBRA continuation coverage* and wish to extend the maximum coverage period, identification of the initial *qualifying event* and its date of occurrence;
- A description of the *qualifying event* (for example, divorce, cessation of dependent status, entitlement to *Medicare* by the *covered employee* or former employee, death of the *covered employee* or former employee, disability of a *qualified beneficiary* or loss of disability status);
- In the case of a *qualifying event* that is divorce, name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*, date of divorce, and a copy of the decree of divorce;
- In the case of a *qualifying event* that is *Medicare* entitlement of the *covered employee* or former employee, date of entitlement, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is a dependent child's cessation of dependent status under the *Plan*, name and address of the child, reason the child ceased to be an eligible *dependent* (for example, attained limiting age, lost student status, married or other);
- In the case of a *qualifying event* that is the death of the *covered employee* or former employee, the date of death, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is disability of a *qualified beneficiary*, name and address of the disabled *qualified beneficiary*, name(s) and address(es) of other family members covered under the *Plan*, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
- In the case of a *qualifying event* that is loss of disability status, name and address of the *qualified beneficiary* who is no longer disabled, name(s) and address(es) of other family members covered under the *Plan*, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no *COBRA continuation coverage*, or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. If the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, the *Plan Administrator* may reject the notice if it does not contain enough information for the *Plan Administrator* to identify the plan, the *covered employee* (or former employee), the *qualified*

beneficiaries, the *qualifying event* or disability, and the date on which the *qualifying event*, if any, occurred.

Electing COBRA continuation coverage

Complete instructions on how to elect *COBRA continuation coverage* will be provided by the *Plan Administrator* within 14 days of receiving the notice of your *qualifying event*. You then have 60 days in which to elect *COBRA continuation coverage*. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If *COBRA continuation coverage* is not elected in that 60-day period, then the right to elect it ceases.

Each *qualified beneficiary* will have an independent right to elect *COBRA continuation coverage*. *Covered employees* may elect *COBRA continuation coverage* on behalf of their spouses, and parents may elect *COBRA continuation coverage* on behalf of their *children*.

In the event that the *Plan Administrator* determines that the individual is not entitled to *COBRA continuation coverage*, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to *COBRA continuation coverage*.

How long does COBRA continuation coverage last?

COBRA continuation coverage will be available up to the maximum time period shown below. Multiple *qualifying events* which may be combined under *COBRA* will not continue coverage for more than 36 months beyond the date of the original *qualifying event*. When the *qualifying event* is “entitlement to *Medicare*,” the 36-month continuation period is measured from the date of the original *qualifying event*. For all other *qualifying events*, the continuation period is measured from the date of the *qualifying event*, not the date of loss of coverage.

When the *qualifying event* is the death of the *covered employee* (or former employee), the *covered employee’s* (or former employee’s) becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a *dependent child*, *COBRA continuation coverage* lasts for up to a total of 36 months.

When the *qualifying event* is the end of employment or reduction of the *covered employee’s* hours of employment, and the *covered employee* became entitled to *Medicare* benefits less than 18 months before the *qualifying event*, *COBRA continuation coverage* for *qualified beneficiaries* other than the *covered employee* lasts until 36 months after the date of *Medicare* entitlement. For example, if a *covered employee* becomes entitled to *Medicare* 8 months before the date on which his or her employment terminates, *COBRA continuation coverage* for his or her spouse and children can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the *qualifying event* (36 months minus 8 months).

Otherwise, when the *qualifying event* is the end of employment (for reasons other than gross misconduct) or reduction of the *covered employee’s* hours of employment, *COBRA continuation coverage* generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of *COBRA continuation coverage* can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the *Plan* is determined by the SSA to be disabled and you notify the *Plan Administrator* as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of *COBRA continuation coverage*, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of *COBRA continuation coverage* and must last at least until the end of the 18-month period of *COBRA continuation coverage*.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another *qualifying event* while receiving 18 months of *COBRA continuation coverage*, the spouse and *dependent children* in your family can get up to 18 additional months of *COBRA continuation coverage*, for a maximum of 36 months, if notice of the second *qualifying event* properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent children* receiving *COBRA continuation coverage* if the *covered employee* or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the *Plan* as a *dependent child*, but only if the event would have caused the spouse or dependent child to lose

coverage under the *Plan* had the first *qualifying event* not occurred. An extra fee will be charged for this extended *COBRA continuation coverage*.

Does *COBRA continuation coverage* ever end earlier than the maximum periods above?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your *participating employer* ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the *qualified beneficiary's* failure to make timely payment of any required premium;
- The date that the *qualified beneficiary* first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either *Medicare* Part A or Part B (whichever comes first); except as stated under *COBRA's* special bankruptcy rules; or
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the *qualified beneficiary* is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for *COBRA continuation coverage*

Once *COBRA continuation coverage* is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, *COBRA continuation coverage* will be canceled and will not be reinstated.

The Trade Act of 2002

Two provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA continuation coverage* within the election period will be allowed an additional 60-day period to elect *COBRA continuation coverage*. If the *qualified beneficiary* elects *COBRA continuation coverage* during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

Special *COBRA* premium assistance opportunity

The Federal Government through the passage of the "American Recovery and Reinvestment Act of 2009" and the "Department of Defense Appropriations Act, 2010" has made a special *COBRA* opportunity available for certain *assistance eligible individuals*.

Reduced *COBRA* premium

For a period not to exceed 15 months, an *assistance eligible individual* is treated as having paid any premium required for *COBRA continuation coverage* under the *Plan* if the individual pays 35% of the premium. Thus, if the *assistance eligible individual* pays 35% of the premium, the *Plan* will treat the individual as having paid the full premium required for *COBRA continuation coverage*, and the individual is entitled to a subsidy for 65% of the premium.

Termination of eligibility for premium assistance

The *assistance eligible individual's* eligibility for the subsidy terminates with the first month beginning on or after the earlier of:

- The date which is 15 months after the first day of the first month for which the subsidy applies;
- The end of the maximum required period of continuation coverage for the qualified beneficiary under the Code's *COBRA* rules or the relevant State or Federal law (or regulation); or

- The date that the *assistance eligible individual* becomes eligible for *Medicare* benefits under Title XVIII of the Social Security Act or health coverage under another group health plan (including, for example, a group health plan maintained by the new employer of the individual or a plan maintained by the employer of the individual's spouse).

However, eligibility for coverage under another group health plan does not terminate eligibility for the subsidy if the other group health plan provides only dental, vision, counseling, or referral services (or a combination of the foregoing), is a health flexible spending account or health reimbursement arrangement, or is coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

If a *qualified beneficiary* paying a reduced premium for *COBRA continuation coverage* under this provision becomes eligible for coverage under another group health plan or *Medicare*, then the qualified beneficiary is required to notify the *Plan* in writing. This notification must be provided to the *Plan* in the time and manner as is specified by the Secretary of Labor. If an *assistance eligible individual* fails to provide this notification at the required time and in the required manner, and as a result the individual's *COBRA continuation coverage* continues to be subsidized after the termination of the individual's eligibility for such subsidy, a penalty will be imposed by the Department of Labor that is equal to 110% of the subsidy provided after termination of eligibility.

Second COBRA election opportunity

The American Recovery and Reinvestment Act of 2009 provides a special 60 day election period for a *qualified beneficiary* who is eligible for a reduced premium and who has not elected *COBRA continuation coverage* as of the date of enactment. The 60 day election period begins on the date the notice is provided to the *qualified beneficiary* of the special election period. However, this special election period does not extend the period of *COBRA continuation coverage* beyond the original maximum required period and any *COBRA continuation coverage* elected pursuant to this special election period begins on the date of enactment and does not include any period prior to that date. Thus, for example, if a covered *employee* involuntarily terminated employment on September 10, 2008, but did not elect *COBRA continuation coverage* and was not eligible for coverage under another group health plan, the *employee* would have 60 days after date of notification of this new election right to elect the coverage and receive the subsidy. If the *employee* made the election, the coverage would begin February 17, 2009, and does not include any period prior to that date. However, the coverage would not be required to last for 18 months. Instead the maximum required *COBRA continuation coverage* period would end no later than 18 months after September 10, 2008.

Election to pay premiums retroactively and maintain COBRA coverage

The Department of Defense Appropriations Act, 2010 allows *assistance eligible individuals* the opportunity to retroactively pay premiums to maintain coverage under the *COBRA* subsidy. These individuals shall be treated as having timely paid their *COBRA* premiums, when:

- The *assistance eligible individual* was covered under the *COBRA* continuation subsidy immediately preceding the enactment of the Department of Defense Appropriations Act, 2010; and
- The *assistance eligible individual* pays such premiums no later than February 17, 2010 (60 days after the enactment date of the Department of Defense Appropriations Act, 2010 on December 19, 2009), or if later, within 30 days of receipt of *COBRA* eligibility notice.

Additional Information

Additional information about the *Plan* and *COBRA continuation coverage* is available from the *Plan Administrator*, who is:

Wilkes University
Human Resources Department
84 West South Street
Wilkes-Barre, PA 18766
Phone: (570)408-7849

Current Addresses

In order to protect your family's rights, you should keep the *Plan Administrator* (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive a *Plan* identification (ID) card which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show your ID card to your *provider* of service. In most cases, your *provider* will file your claim for you. You may file the claim yourself by submitting the required information to:

First Priority Health
19 North Main St.
Wilkes-Barre, PA 18711
Phone (888) 338-2211

Most claims under the *Plan* will be "*post service claims.*" A "*post service claim*" is a claim for a benefit under the *Plan* after the services have been rendered. *Post service claims* must include the following information in order to be considered filed with the *Plan*:

A Form HCFA or Form UB92 completed by the *provider* of service, including:

- The date of service;
- The name, address, telephone number and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

A call from a *provider* who wants to know if an individual is covered under the *Plan*, or if a certain procedure or treatment is a *covered expense* before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the *Plan*. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures For All Claims

The procedures outlined below must be followed by *covered persons* to obtain payment of health benefits under this *Plan*.

Health Claims

All claims and questions regarding health claims should be directed to the *third party administrator*. The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with *ERISA*. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the *covered person* is entitled to them. The responsibility to process claims in accordance with the *summary plan description* may be delegated to

the *third party administrator*; provided, however, that the *third party administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *covered person* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were *incurred* or that the benefit is covered under the *Plan*. If the *Plan Administrator* in its sole discretion shall determine that the *covered person* has not *incurred a covered expense* or that the benefit is not covered under the *Plan*, or if the *covered person* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

Appeal Procedures

The self-funded health benefits program (“Plan”) has a review and an appeal procedure. If any portion of an initial claim submission is not paid, there is a denial of services in whole or in part, or the Participant does not understand or agree with the handling of an initial claim determination or denial of services, there are several steps the Participant can take.

Many questions can be answered quickly calling the Customer Service number listed on the Identification Card of the Participant. If the Participant is not satisfied with the handling of the claim after this step, the following procedures may be pursued:

If the Participant, or his/her dependents, have filed an initial claim for benefits and the claim is denied (in whole or in part), the Participant will be notified in writing, typically by an Explanation of Benefits or Notice of Certification, detailing the following:

- Specific reasons for the denial;
- Specific references to any provisions of the Plan under which the denial was made;
- The specific rule, guideline, protocol, or other similar criterion relied upon in making the decision or a statement that a copy of the rule, guideline, protocol, or other similar criterion is available upon request;
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances or a statement that such explanation will be provided free of charge upon request;
- A description of any additional material or information needed to perfect the claim with an explanation of why it is needed;

The Explanation of Benefits or Notice of Certification is provided to the Participant as an initial benefit determination.

The Participant may file for a review of the initial claim determination or denial of service with the claims administrator, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE. BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH will perform the following functions:

- Gather data related to the claim that may include the following information:
 - o Claims information
 - o Customer Service inquiries
 - o Referral or Precertification information
 - o Medical Policy Information
 - o Medical records
 - o Any additional information relied upon in making the decision
- When a denial is based on medical judgment, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH shall provide for a review of the claim by a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan delegates to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH the authority to make determinations with respect to administrative services in regard to Covered Services under the Plan on behalf of the Plan, and to provide benefits in accordance with BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE’s medical policies. Such authority to apply the Plan rules and terms, to make factual

determinations in connection with requests for benefits under the Plan, to determine what constitutes experimental or investigative services or supplies pursuant to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE's established policy, and to determine the medical necessity of providing benefits under the Plan.

BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH shall act as a fiduciary under the laws of the Commonwealth of Pennsylvania in connection with the exercise of its responsibilities regarding benefit terminations and reviews of denied claims for benefits under the Plan. BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH shall not be deemed a fiduciary for purposes of determining eligibility of persons for coverage under the Plan.

As provided for in the Summary Plan Description (SPD) or Plan Document, BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH will review this information and make a final determination, as fiduciary, with regard to a denial of an initial claim or a denial of services, in whole or in part. Final determinations denied on the basis of medical judgment are eligible for external review. The participant may file for an external review of the final determination by submitting a written request to BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY LIFE. External review determinations will be made by a certified Independent Review Organization assigned by the Pennsylvania Department of Health.

If the Participant intends to request an appeal of an initial determination by BLUE CROSS, FIRST PRIORITY HEALTH OR FIRST PRIORITY HEALTH or to formally appeal a claim that has been denied, it must be filed within the time frames specified in the Summary Plan Description (SPD) or Plan Document. The Participant has the right to see all material relating to their claim and submit any comments or supporting documentation they wish for consideration. The SPD is prepared and made available from the Participant's employer or through the entity that sponsors the self-funded medical Plan.

If the Participant is a member of an ERISA group, the Participant may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, once administrative remedies have been exhausted.

Appointment of Authorized Representative

A *covered person* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *covered person* to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the *covered person* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator*. However, in connection with a claim involving urgent care, the *Plan* will permit a health care professional with knowledge of the *covered person's* medical condition to act as the *covered person's* authorized representative without completion of this form. In the event a *covered person* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *covered person*, unless the *covered person* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *covered person* whose *illness* or *injury* is the basis of a claim. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan Administrator* may reasonably require during the pendency of a claim. The *covered person* must comply with this requirement as a necessary condition to coverage.

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *covered person* whose *illness* or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. Dollars, to the covered *employee* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate,

the *Plan Administrator* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the *Plan Administrator*, is or was providing the care and support of such *employee*.

Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *covered person* to the *provider*; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers

Medical expenses for care, supplies or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a “*non-U.S. provider*”) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a *non-U.S. provider*;
- The *covered person* is responsible for making all payments to *non-U.S. providers*, and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the *Plan* in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the *Plan*'s terms, conditions, limitations or exclusions. Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *covered person* or *dependent* on whose behalf such payment was made.

A *covered person*, *dependent*, *provider*, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *covered person* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *covered person* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards

approved by the *Plan Administrator* or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *covered person, provider* or other person or entity to enforce the provisions of this section, then that *covered person, provider* or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage

A *covered person's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *covered person*. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *covered person*, as required by the state Medicaid program; and the *Plan* will honor any *subrogation* rights the state may have with respect to benefits which are payable under the *Plan*.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this *Plan*.

Excess Insurance

If at the time of *injury, sickness, disease, or disability* there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage. The *Plan's* benefits shall be excess to:

- Any responsible third party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured, or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

Vehicle limitation

When medical payments are available under any vehicle insurance, the *Plan* shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This *Plan* shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

“Allowable Expenses”

“*Allowable expenses*” shall mean any *medically necessary, usual, reasonable and customary* item of expense, at least a portion of which is covered under this *Plan*. When some *other plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of *other plan(s)* for payment of benefits. If you fail to properly file for, and receive payment by, any *other plan(s)*, this *Plan* will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the “Application to Benefit Determination” calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this *Plan* will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the *covered person* does not use an HMO provider, this *Plan* will not consider as *allowable expenses* any charge that would have been covered by the HMO had the *covered person* used the services of an HMO provider.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. If this Plan is a secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative *allowable expenses* for that calendar year; however, in no event will this Plan pay more than it would have in the absence of any *other plan(s)*. When there is a conflict in the order of benefit determination, this *Plan* will never pay more than 50% of *allowable expenses*.

When medical payments are available under automobile insurance, this *Plan* will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when:

- The *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined; and
- The rules in the section entitled “Order of Benefit Determination” would require this *Plan* to determine its benefits before the *other plan*.

Order of Benefit Determination

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The *Plan* will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;
- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent.
- If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this *Plan* with respect to *allowable expenses* in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the *Plan* shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this *Plan*.

Coordination of Benefits with Medicare

If you are eligible for *Medicare*, and you are eligible for coverage under this *Plan*, you may choose to continue coverage under this *Plan*, and any *Medicare* benefits to which you are entitled may be used to supplement the benefits of this *Plan*. If, however, you choose to make *Medicare* your primary plan, you may not supplement your *Medicare* coverage with the benefits of this *Plan*.

In all cases, coordination of benefits with *Medicare* will conform with Federal law. When coordination of benefits with *Medicare* is permitted, each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage whether or not the individual has enrolled for full coverage. Your benefits under this *Plan* will be secondary to *Medicare* to the extent allowed by Federal law.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this *Plan*.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Benefits Subject to this Provision

This provision shall apply to all benefits provided under any section of this *Plan*.

When this Provision Applies

A *covered person* may incur medical or other charges related to *injuries* or *illness* caused by the act or omission of another person; or *another party* may be liable or legally responsible for payment of charges *incurred* in connection with the *injuries* or *illness*. If so, the *covered person* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the *Plan* will be secondary, not primary, and the *Plan* will be *subrogated* to all rights the *covered person* may have against that other person or *another party* and will be entitled to *reimbursement*. In addition, the *Plan* shall have the first lien against any *recovery* to the extent of benefits paid or to be paid and expenses *incurred* by the *Plan* in enforcing this provision. The *Plan's* first lien supercedes any right that the *covered person* may have to be “made whole.” In other words, the *Plan* is entitled to the right of first *reimbursement* out of any *recovery* the *covered person* procures or may be entitled to procure regardless of whether the *covered person* has received compensation for any of his or her damages or expenses, including any of his or her

attorneys' fees or costs. Additionally, the *Plan's* right of first *reimbursement* will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the *Plan*, the *covered person* agrees that acceptance of benefits is constructive notice of this provision.

The *covered person* must:

- Execute and deliver a subrogation and reimbursement agreement;
- Authorize the *Plan* to sue, compromise and settle in the *covered person's* name to the extent of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount, and assign to the *Plan* the *covered person's* rights to *recovery* when this provision applies;
- Immediately reimburse the *Plan*, out of any *recovery* made from *another party*, 100% of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) *incurred* by the *Plan* in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
- Notify the *Plan* in writing of any proposed settlement and obtain the *Plan's* written consent before signing any release or agreeing to any settlement; and
- Cooperate fully with the *Plan* in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the *Plan*.

When a right of recovery exists, and as a condition to any payment by the *Plan* (including payment of future benefits for other *illnesses* or *injuries*), the *covered person* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by the *Plan*, as well as doing and providing whatever else is needed, to secure the *Plan's* rights of *subrogation* and *reimbursement*, before any medical or other benefits will be paid by the *Plan* for the *injuries* or *illness*. The *Plan Administrator* may determine, in its sole discretion, that it is in the *Plan's* best interests to pay medical or other benefits for the *injuries* or *illness* before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the *Plan* still will be entitled to *subrogation* and *reimbursement*. In addition, the *covered person* will do nothing to prejudice the *Plan's* right to *subrogation* and *reimbursement* and acknowledges that the *Plan* precludes operation of the made-whole and common-fund doctrines. A *covered person* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *covered person* who receives any such *recovery* and does not immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for the *Plan*, because the *covered person* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

The *Plan Administrator* has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to *subrogation* or *reimbursement*. In no case will the amount subject to *subrogation* or *reimbursement* exceed the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount. The *Plan* has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the *covered person* does not receive full compensation for all of his or her charges and expenses.

When *Recovery* Includes the Cost of Past or Future Expenses

In certain circumstances, a *covered person* may receive a *recovery* that includes amounts intended to be compensation for past and/or future expenses for treatment of the *illness* or *injury* that is the subject of the *recovery*.

This *Plan* will not cover any expenses for which compensation was provided through a previous *recovery*. This exclusion will apply to the full extent of such *recovery* or the amount of the expenses submitted to the *Plan* for payment, whichever is less. The *Plan* also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the *covered person* to inform the *Plan Administrator* when expenses are related to an *illness* or *injury* for which a *recovery* has been made. Acceptance of benefits under this *Plan* for which the *covered person* has received a *recovery* will be considered fraud, and the *covered person* will be subject to any sanctions determined by the *Plan Administrator*, in its sole discretion, to be appropriate. The *covered person* is required to submit full and complete documentation of any such *recovery* in order for the *Plan* to consider eligible expenses that exceed the *recovery*.

“Another Party”

“*Another party*” shall mean any individual or entity, other than the *Plan*, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered person’s injuries* or *illness*.

“*Another party*” shall include the party or parties who caused the *injuries* or *illness*; the insurer, guarantor or other indemnifier of the party or parties who caused the *injuries* or *illness*; a *covered person’s* own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the *injuries* or *illness*.

“Recovery”

“*Recovery*” shall mean any and all monies paid to the *covered person* by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the *injuries* or *illness*. Any *recovery* shall be deemed to apply, first, for *reimbursement*.

“Subrogation”

“*Subrogation*” shall mean the *Plan’s* right to pursue the *covered person’s* claims for medical or other charges paid by the *Plan* against *another party*.

“Reimbursement”

“*Reimbursement*” shall mean repayment to the *Plan* for medical or other benefits that it has paid toward care and treatment of the *injury* or *illness* and for the expenses incurred by the *Plan* in collecting this benefit amount.

When a Covered Person retains an Attorney

If the *covered person* retains an attorney, that attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other *illnesses* or *injuries*. Additionally, the *covered person’s* attorney must recognize and consent to the fact that the *Plan* precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine in his or her pursuit of *recovery*. The *Plan* will not pay the *covered person’s* attorneys’ fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the *covered person’s* attorneys’ fees and costs. Attorneys’ fees will be payable from the *recovery* only after the *Plan* has received full *reimbursement*.

An attorney who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *covered person’s* attorney who receives any such *recovery* and does not immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for the *Plan*, because neither the *covered person* nor his or her attorney is the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

When the Covered Person is a Minor or is Deceased

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor *covered person* and to the heir or personal representative of the estate of a deceased *covered person*, regardless of applicable law and whether or not the representative has access or control of the *recovery*.

When a Covered Person Does Not Comply

When a *covered person* does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *covered person* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as *reimbursement* to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required *reimbursement*. If the *Plan* must bring an action against a *covered person* to enforce the provisions of this section, then that *covered person* agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

DEFINITIONS

These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.

1. ADJUNCTIVE PROCEDURES – Physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization performed by an individual holding the appropriate licensure and certification.
2. ALCOHOL AND/OR DRUG ABUSE – Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of this Policy, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).
3. ALLOWABLE CHARGE – The Allowable Charge is established by a Provider Agreement and will be accepted by the Participating Provider as payment in full for Covered Services less any Participant liability, as a specified herein and in the Outline of Coverage. In the case of a Participant Provider, Participant liability will be calculated on the Allowable Charge or on the billed charge, whichever less.

In the case of a Non-Participating Provider, when Prior Authorization is obtained, the percentage of cost-sharing will be the same as that which the Participant would have been responsible for if the Participant had received services from a Participating Provider. Non-Participating Providers will accept the Plan payment as payment in full for prior authorized Covered Services less any Participant cost-sharing. As specified herein and in the Outline of Coverage.

Participants may contact BlueCare Service Representative toll-free at 1-800-822-8753 weekdays during normal business hours for a determination of Covered Services. Hearing impaired persons can call (TDD) 1-800-413-1112. Participants may also write to:

First Priority Health
19 North Main Street
Wilkes Barre, PA 18711

4. ALTERNATIVE TREATMENT PLAN – A voluntary program whereby the Insured is offered cost-effective treatment alternatives in lieu of the stated benefits in this Policy, without compromising the quality of care. First Priority Life's Care Management Department, in cooperation with the Physician, organizes and coordinates care through multi-disciplinary resources.
5. AMBULATORY SURGICAL FACILITY – A Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, by the Accreditation

Association for Ambulatory Health Care, Inc., or a similar accrediting agency acceptable to First Priority Health which:

- a. has permanent facilities and equipment for the purpose of performing surgical procedures on an Outpatient basis;
- b. provides nursing services and treatment by or under the supervision of Physicians whenever the patient is in the facility;
- c. does not provide Inpatient accommodations; and
- d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

6. **APPLIED BEHAVIORAL ANALYSIS** – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

8. **AUTISM SPECTRUM DISORDER (ASD)** – Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.

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

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

11. **BENEFIT PERIOD** – A Calendar Year or a Benefit Year.

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

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

14. **BUSINESS DAY** – A day that First Priority Health is open for business.

15. **CALENDAR YEAR** – A one-year period which begins on January 1 and ends on December 31.

16. **CERTIFICATE OF CREDITABLE COVERAGE** – A statement prepared by First Priority Health, in accordance with the Health Insurance Portability and Accountability Act (“HIPAA”) regulations, for Participants who terminate coverage under the Agreement. The Statement listed the dates of continuous coverage in the Preferred Provider Organization Agreement and can be used to establish credit toward a waiting period for pre-existing conditions in another health insurance program. A certificate of Creditable Coverage will be provided to each Participant at the time the individual ceases to be covered under the Agreement. You can request an additional Certificate of Creditable Coverage by contacting the appropriate BlueCare Service Representative.

17. **CHEMOTHERAPY** – The treatment of disease by chemical or biological therapeutic agents.
18. **CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)** – A form of manual treatment to influence joint and neurophysiological function or the use of Adjunctive Procedures in treating misaligned and displaced vertebrae or articulation and related conditions of the nervous system provided by an individual holding the appropriate licensure and/or certification.
19. **COINSURANCE MAXIMUM** – A specified dollar amount of Coinsurance incurred by an Insured, as set forth in the Declaration and the Schedule of Benefits, for Covered Services in a Benefit Period. (Refer to the Declaration and the Schedule of Benefits for the period selected by the Policy Holder.) The Coinsurance Maximum does not include removal of bony impacted wisdom teeth when performed by a Preferred Provider, penalties for failure to obtain Pre-Certification, Deductibles, Copayments, amounts in excess of the Allowable Charge, charges for non-Covered Services and charges after Covered Services have been exhausted, and any Deductible or Copayment amounts payable by the Insured for Covered Services under any rider attached to this Policy.
20. **COMMUNITY BEHAVIORAL HEALTHCARE NETWORK OF PENNSYLVANIA (CBHNP)** – First Priority Life's dedicated unit that provides eligibility verification, triage, referral and utilization management for mental health-chemical recovery (behavioral health) services.
21. **COPAYMENT** – The amount, if any, an Insured must pay directly to Providers in connection with Covered Services set forth in this Policy and in the Declaration and the Schedule of Benefits.
22. **COSMETIC PROCEDURE** – A medical or surgical procedure which is primarily performed to improve the appearance of any portion of the body.
23. **COVERED SERVICE (Covered Medical Expense)** – A service or supply specified in this Policy for which benefits will be provided pursuant to the terms of this Policy.
24. **CUSTODIAL CARE** – Services to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of skilled, trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, rehabilitation potential, or place of service.
25. **DEDUCTIBLE** – A specified amount of Covered Services, as set forth in the Declaration and the Schedule of Benefits, expressed in dollars that must be incurred by an Insured before First Priority Health will assume any liability for all or part of the remaining Covered Medical Expenses.
26. **DEPENDENT** – The spouse or same-sex domestic partner of an Insured; or the Insured's or the Insured's spouse's or the insured's same-sex domestic partner's unmarried child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.
27. **DETOXIFICATION** – The process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol, drug or other drug dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.
28. **DIAGNOSTIC ASSESSMENT OF ASD** – Medically necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician Assistant, licensed Psychologist or Certified Registered Nurse Practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

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

- a. diagnostic imaging;
- b. diagnostic pathology, consisting of laboratory and pathology tests;
- c. diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by First Priority Life; and
- d. allergy testing consisting of percutaneous, intracutaneous and patch tests.

30. **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.

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

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

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

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

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

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

36. **FIRST PRIORITY HEALTH NETWORK (“FPH Network”)** – The BlueCare HMO Network or any other Participating Provider network sponsored by the First Priority Health.

37. **FOLLOW-UP CARE** – Medical care necessary to treat an illness or injury subsequent to the initial treatment.

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

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

40. GUEST MEMBERSHIP – A temporary courtesy enrollment in a host Health Maintenance Organization (“HMO”) that enables Participants who are living away from home to receive a comprehensive range of Covered Services, including routine and preventive services. A Participant enrolled in Guest Membership remains a First Priority Health Participant and premium continues to be paid to First Priority Health.

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

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

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

- a. provides skilled Outpatient services on a visiting basis in the Insured's home; and
- b. is responsible for supervising the delivery of such services under a plan authorized by the Physician.

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

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

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

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

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

- a. is a duly licensed institution;
- b. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- c. has organized departments of medicine and/or major Surgery;
- d. provides 24-hour nursing service by or under the supervision of Registered Nurses; and
- e. is not, other than incidentally, a:
 - Skilled Nursing Facility
 - nursing home
 - Custodial Care home
 - health resort

- spa or sanitarium
- place for rest
- place for the aged
- place for the provision of Hospice Care, or
- personal care home.

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

50. IMMEDIATE FAMILY – The Insured's spouse, same-sex domestic partner, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

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

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

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

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

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

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

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

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

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

b. LIFETIME BENEFIT MAXIMUM – The greatest benefit amount payable by First Priority Health in the Insured's lifetime set forth in the Declaration and the Schedule of Benefits.

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

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

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

- b. provided for the diagnosis, or the direct care and treatment of the Insured's condition, illness, disease or injury;
- c. in accordance with current standards of medical practice;
- d. not primarily for the convenience of the Insured, or the Insured's Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Insured. When applied to hospitalization, this further means that the Insured requires acute care as an Inpatient due to the nature of the services rendered or the Insured's condition, and the Insured cannot receive safe or adequate care as an Outpatient.

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

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

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

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

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

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

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

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

69. **OUT-OF-AREA CARE FOR UNEXPECTED CONDITION** – Outpatient medical care that is required, while the Participant is outside of the area serviced First Priority Health's Network of Providers, for an unexpected condition that is not life threatening and cannot reasonably be postponed until the Participant returns to the area serviced by First Priority Health's Network of Providers.

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

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

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

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

74. PARTICIPATING FACILITY PROVIDER – An approved Facility Provider which has an agreement with First Priority Health pertaining to payment for Covered Services rendered to a Participant.

75. PARTICIPATING PROFESSIONAL PROVIDER – A non-Facility Provider which or who has entered into a contractual agreement with First Priority Health for the provision of services to Participants on an agreed-upon basis.

76. PARTICIPATING PROVIDER AGREEMENT – An agreement between a Provider and First Priority Health pursuant to which negotiated rates are established for payment of Covered Services rendered to a Participant.

77. PHARMACY CARE – Medications prescribed by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner to determine the need or effectiveness of such medications.

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

79. PRIMARY CARE PHYSICIAN – A Physician, who supervises, coordinates and provides initial care and basic medical services to Participants as a general or family practitioner, an internist, or a pediatrician, and maintains continuity of patient care.

80. PRIOR AUTHORIZATION – The process whereby Participating Providers, including the Participant’s Primary Care Physician as well as Participating Providers of a Host Blue located outside of the area serviced by First Priority Health’s Network, obtain approval from First Priority Health for Covered Services prior to the date of services. Prior Authorization is usually conducted via telephone, telefax, or electronically and the process results in the issuance of a Prior Authorization number by First Priority Health, without which the claim will not be paid. It is the responsibility of a Participating Provider to obtain Prior Authorization, when required, in accordance with First Priority Health’s policies and procedures. First Priority Health may add or delete services, which require Prior Authorization, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan at the address on the records of First Priority Health at least thirty (30) days in advance of such change.

With regard to prescription drug Covered Services, Prior Authorization means the process whereby the prescriber and/or Participant is given prior approval by First Priority Health for certain prescription drugs, including drug formulary exceptions, and utilization review criteria, which have been designated by First Priority Health as requiring Prior Authorization. It is the responsibility of the Participant to obtain Prior Authorization for prescription drug Covered Services, when required, in accordance with First Priority Health’s policies and procedures. The Participant’s Physician must complete the form and send it to First Priority Health by fax or electronically. The director of pharmacy will review the request and provide a decision based on Medical Necessity. If the Participant’s prescription has been authorized, coverage for the drug will be made available and the Participant will be notified of the decision in writing.

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

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

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

- _ Nurse Practitioner
- _ Occupational Therapist

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

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

a. PARTICIPATING PROVIDER – A Provider who signed a Participating Provider Agreement with First Priority Health or a Participating Provider of a Host Blue located outside the geographic area serviced by First Priority Health, who signed a Provider Agreement with their on-site Blue Cross and/or Blue Shield Licensee. Participants can verify whether a Provider is in the First Priority Health Network or is a Participating Provider of a Host Blue by contacting their Primary Care Physician or consulting the Provider directories located on the web site, www.bcnepa.com. Participants may also contact BlueCare Service Representatives toll-free at 1-800-822-8753 weekdays during normal business hours. Hearing impaired persons can call (TTY) 1-800-413-1112.

b. NON-PARTICIPATING PROVIDER – A Provider who has not signed a Participating Provider Agreement with First Priority Health and is not a Participating Provider of a Host Blue.

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

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

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

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

89. PSYCHOLOGIST – A licensed clinical Psychologist.

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

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

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

93. REHABILITATIVE CARE – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human

behavior or to prevent loss of attained skill or function.

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

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

96. **SAME-SEX DOMESTIC PARTNER(S)** – Refers to an individual who is a member of a domestic partnership consisting of two partners of the same sex each of whom: (i) is at least eighteen (18) years of age or older; (ii) resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (iii) is not related to the other partner by adoption or blood; (iv) is the sole Same-Sex Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this Same-Sex Domestic Partnership for the last six (6) months; (v) agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and (vi) is able to demonstrate financial interdependence by submission of proof of three (3) or more of the following documents:

- a. a Same-Sex Domestic Partner Agreement;
- b. a joint mortgage or lease;
- c. a designation of one of the partners as beneficiary in the other partner’s will;
- d. a durable property and health care powers of attorney;
- e. a joint title to an automobile, or joint bank account or credit account; or
- f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

97. **SAME-SEX DOMESTIC PARTNERSHIP** – The relationship established between a Same-Sex Domestic Partner, as defined in this Section, and an Insured whereby the Insured has filed a notarized affidavit with the Insured’s Group and First Priority Life certifying that they meet the criteria of Same-Sex Domestic Partners, as defined herein, and that the requirements evidencing such a relationship have been fulfilled.

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

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

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

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

102. **SPECIALIST PHYSICIAN** – A Physician who provides medical care in any generally accepted medical specialty or subspecialty.

101. **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.

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

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

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

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

107. THERAPY SERVICE – Services or supplies used for the treatment of an illness or injury to promote the recovery of an Insured. Therapy Services are covered to the extent specified in this Policy.

- a. CARDIAC REHABILITATION THERAPY – An exercise program, which is effective in the physiological and psychological rehabilitation of patients with cardiac conditions.
- b. COGNITIVE REHABILITATION THERAPY – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain injury.
- c. DIALYSIS TREATMENT – The treatment of acute renal failure or chronic irreversible renal insufficiency or removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- d. OCCUPATIONAL THERAPY – The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- e. PHYSICAL THERAPY – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part performed by a licensed Physical Therapist.
- f. PULMONARY REHABILITATION THERAPY – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders.
- g. RADIATION THERAPY – The treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- h. RESPIRATORY THERAPY – The introduction of dry or moist gases into the lungs for treatment purposes.
- i. SPEECH THERAPY – The treatment for the correction of a speech impairment resulting from disease, surgery, injury, anomalies or previous therapeutic processes.

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

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

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

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

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?

The *Plan* is administered by the *Plan Administrator* in accordance with *ERISA*. The *Plan Administrator* has retained the services of the *Third Party Administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will 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* will 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 (including the determination of what services, supplies, care and treatments are *experimental*), to decide disputes which may arise relative to a *covered person's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *covered person* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *covered person's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by *ERISA*;
- To establish and communicate procedures to determine whether *MCSOs* and *NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

May changes be made to the *Plan*?

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by *ERISA*. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of *covered persons* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

MISCELLANEOUS INFORMATION

Who pays the cost of the *Plan*?

The *Plan Sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan Sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *covered person's* contribution (if any) will be determined from time to time by the *Plan Sponsor*, in its sole discretion.

Will the *Plan* release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *covered person* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *covered person* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *covered persons* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Will the *Plan* conform with applicable laws?

This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*. It is intended that the *Plan* will conform to the requirements of *ERISA*, as it applies to employee welfare plans, as well as any other applicable law.

What constitutes a fraudulent claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a *covered person* in the *Plan*;
- Attempting to file a claim for a *covered person* for services that were not rendered or *drugs* or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?

The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Covered persons* are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this *summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

How may a *Plan* provision be waived?

No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this summary plan description a contract between the employer and covered persons?

This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *covered person* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

What if there is coverage through workers’ compensation?

This *Plan* excludes coverage for any *injury* or *illness* that is eligible for coverage under any workers’ compensation policy or law regardless of the date of onset of such *injury* or *illness*. However, if benefits are paid by the *Plan* and it is later determined that you received or are eligible to receive workers’ compensation coverage for the same *injury* or *illness*, the *Plan* is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the *injury* or *illness* regardless of the amount or terms of any settlement you receive from workers’ compensation. The *Plan* will exercise its right to recover against you. The *Plan* reserves its right to exercise its rights under this section and the section entitled “Recovery of Payment” even though:

- The workers’ compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;
- The amount of workers’ compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers’ compensation carrier; or
- The health care expense is specifically excluded from the workers’ compensation settlement or compromise.

You are required to notify the *Plan Administrator* immediately when you file a claim for coverage under workers’ compensation if a claim for the same *injury* or *illness* is or has been filed with this *Plan*. Failure to do so, or to reimburse the *Plan* for any expenses it has paid for which coverage is available through workers’ compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the *Plan* for recovery and disciplinary action.

Will the *Plan* cover an alternate course of treatment?

The *Plan Administrator* may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this *Plan*, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this *summary plan description*.

If a *covered person*, in cooperation with his or her *provider*, elect a course of treatment that is deemed by the *Plan Administrator*, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the *illness* or *injury*, this *Plan* will allow coverage for the *usual, customary and reasonable* value of the less costly or extensive course of treatment.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (the "*privacy standards*"), the *Plan* may disclose *summary health information* to the *Plan Sponsor*, if the *Plan Sponsor* requests the *summary health information* for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan*; or
- Modifying, amending or terminating the *Plan*.

"*Summary health information*" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan*, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan* documents or as *required by law* (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor*, except pursuant to an authorization which meets the requirements of the *privacy standards*;
- Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services (“*HHS*”), or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);
- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - The following employees, or classes of employees, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed:
 - Director, Human Resources
 - Benefits Coordinator
 - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
 - In the event any of the individuals described in above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI*, the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“*Plan administration*” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the *Plan* or solicit bids from prospective issuers. “*Plan administration*” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the *Plan Sponsor*

Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor*.

Disclosure of *PHI* to Obtain Stop-loss or Excess Loss Coverage

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator*, to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters

(“*MGUs*”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards*.

Other Disclosures and Uses of *PHI*

With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards*.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI;
- Report to the *Plan* any Security Incident of which it becomes aware;
- Notify *participants* of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318); and
- Notify the Federal Trade Commission of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318).

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

STATEMENT OF *ERISA* RIGHTS

As a *covered person* in the *Plan*, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all *covered persons* are entitled to:

Receive Information About Your *Plan* and Benefits

Examine, without charge, at the *Plan Administrator*'s office and at other specified locations, such as worksites, all documents governing the *Plan*, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated *summary plan description*. The *Plan 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 *covered person* with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or *dependents* if there is a loss of coverage under the *Plan* as a result of a *qualifying event*. You or your *dependents* may have to pay for such coverage. Review this *summary plan description* and the documents governing the *Plan* on the rules governing your *COBRA* continuation coverage rights.

You should be provided a *certificate of coverage*, free of charge, from your group health plan or health insurance issuer on request or when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, you may be subject to a *pre-existing condition* exclusion or limitation for 12 months (18 months for *late enrollees*) after your *enrollment date* in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for *covered persons*, *ERISA* imposes duties upon the people who are responsible for the operation of the *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 *covered persons* and beneficiaries. No one, including your *participating employer* or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan’s* decision or lack thereof concerning the qualified status of a domestic relations order, a *medical child support order* or a *national medical support notice*, you may file suit in 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 would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the *Plan*, you should contact the *Plan Administrator*. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the *Plan Administrator*, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration.