

Company Name:	Hope Enterprises	Group Number(s):	055142000, 055142099
Company Code:	201695	Dependent/Student Age Limit:	19/23 end of month
Effective Date:	8/1/2010	New Born Children:	31 days
Renewal Date:	8/1/2011	Full-time student leave of absence:	Covered
Date - Part II Benefit Schedule:	7/1/2010	Domestic Partners:	Not Covered
Outline of Coverage Revision Date:	6/1/2010	Credit (initial benefit period only)	0
		Claims Appeal Fiduciary	Plan
		Benefit Period	Calendar Year

Participant Responsibility				Benefit Change Date/ Non-Standard Change Date
	Preferred*	Non-Preferred**	Limitations/ Non-Standard	
Deductible per person	\$250	\$500	Per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Deductible per family	\$750	\$1,500	Aggregate Deductible per benefit period. Deductible applies to all services unless otherwise noted. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance	20%	40%	Allowable Charge ¹	
Coinsurance maximum per person	\$1,000	\$4,000	Per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Coinsurance maximum per family	\$3,000	\$8,000	Aggregate Coinsurance Maximum, per benefit period. Preferred does not apply toward Non-Preferred; Non-Preferred applies toward Preferred.	
Lifetime Maximum	\$1,000,000		combined	
Primary Care Office Visits	\$20	40%	Unlimited Visits. Preferred coverage not subject to deductible.	
Specialty Care Office Visits	\$20	40%	Unlimited Visits. Preferred coverage not subject to deductible.	
Newborn Children	20%	40%	Newborn child claims are not subject to the deductibles	
Precertification Penalty (facility)	None	\$500		
Preventive Care Services				
Childhood Immunizations	0%	40%	Copay applies if office visit. Coinsurance applies if no office visit. Pediatric Preferred/Non-Preferred not subject to deductible.	

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Routine gynecological exam and Pap Smears	\$20	40%	Preferred/Non-Preferred not subject to deductible. One routine exam per benefit period.	
Routine Physical Exams	\$20	40%	Preferred not subject to deductible.	
Mammography screenings/ diagnostic	0%	40%	Preferred/Non-Preferred not subject to deductible. Preferred not subject to coinsurance. Mammography screenings age 40+	8/1/2010
Routine colorectal cancer and prostate cancer screening	0%	40%	Preferred/Non-Preferred not subject to deductible. Preferred not subject to coinsurance	8/1/2010
Emergency Services				
Ambulance Emergency Transport	20%	20%		
Ambulance - Non-Emergency Transport	20%	20%		
Emergency room visit	\$30	\$30	Preferred/ Non-Preferred not subject to deductible or coinsurance, copay waived if admitted to hospital. Emergency room physicians apply a 20% coinsurance, not subject to deductible	
Inpatient Services				
Inpatient Copay per admission	Not Applicable	Not Applicable		
Inpatient hospital services	20%	40%	unlimited days per benefit period.	
Inpatient Rehabilitation	20%	40%	45 days per benefit period.	
Skilled nursing care	20%	40%	100 days per benefit period.	
Transplants	20%	40%	\$25,000 maximum on organ and tissue procurement per transplant.	
Outpatient Services				
High-tech imaging (MRI, MRA, CT, PET Scans, nuclear cardiology)	20%	40%		
Diagnostic testing (lab tests, x-ray, etc.)	20%	40%		
Maternity care (outpatient Physician visits)	\$20	40%	neonatal circumcision is covered. Copay for initial office visit.	
Radiation, dialysis or chemotherapy	20%	40%	Preferred deductible waived for in office and copay is waived	
Physical Therapy	\$20	40%	30 visits per Benefit Period. Preferred not subject to deductible or coinsurance	
Speech Therapy	\$20	40%	30 visits per Benefit Period. Preferred not subject to deductible or coinsurance	
Occupational Therapy	\$20	40%	30 visits per Benefit Period. Preferred not subject to deductible or coinsurance	
Pulmonary Rehabilitation Therapy	20%	40%	18 visits per benefit period.	

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Cardiac Rehabilitation	20%	40%	30 visits per Benefit Period. Preferred not subject to deductible or coinsurance	
Respiratory therapy	20%	40%	18 visits per benefit period.	
Surgery	20%	40%	\$20 copay only applies for surgery provided in the physician's office not subject to coinsurance	
Other Services				
Allergy Injections	0%	40%	Not subject to deductible, if office visit copay applies	
Autism Spectrum Disorders	20%	40%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21. Coverage is subject to any applicable copays, coinsurance, and/or deductible. \$36,000 limit per member per benefit period.	
Chiropractic manipulative benefits	Not covered	Not Covered		
Durable medical equipment, Prosthetics, & Orthotics	20%	40%	\$10,000 maximum per benefit period combined durable medical equipment, prosthetics, and orthotics, and ostomy supplies. Diabetic items are excluded from this dollar maximum. catheter supplies, support stockings (2 per benefit period), surgical dressings and other medical supplies are covered. Prosthetic repair/replacement is covered when due to normal use or physiological change. Common first aid supplies are not covered. Orthopedic shoes or corrective shoes are not covered unless part of a leg brace are not covered.	
Ostomy Supplies	20%	40%	\$10,000 maximum per benefit period combined durable medical equipment, prosthetics, and orthotics. All ostomy supplies are covered	
Home health services	20%	40%	100 visit limit per benefit period	
Home Infusion (nurse visit)	20%	40%	nurses visit only.	
Hospice care	20%	40%	Unlimited	
Private Duty Nursing	20%	40%		

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Oral Surgery	20%	40%	general anesthesia related to non-covered dental procedures or non-covered oral surgery when approved by a medical director for children under age 18, adults with significant cognitive impairment or those with complex medical conditions is covered	8/1/2010
Morbid Obesity	Not covered	Not covered		
Nutritional Therapy	\$10	40%	6 visits per member per benefit period. Preferred not subject to deductible.	
Bony impacted wisdom teeth	20%	40%		
Prescription Glasses/Contacts Following Cataract Surgery	20%	40%	Post-cataract prescription glasses or contact lenses are covered, limited to a lifetime maximum of \$350 per member.	
Infertility	20%	40%	Diagnostic services leading up to the diagnosis of infertility. Applicable copayment for office visits.	
Invitro Fertilization	Not covered	Not covered		
Artificial Insemination	Not covered	Not covered		
Non-elective abortion	20%	40%		
Voluntary Sterilization	20%	40%	Reversals not covered.	
Podiatry Services	0%	40%	Office Visits and surgery are covered with deductible waived. Copay applies to office visit	
Prescription Drugs				
Deductible per person	None	Not Covered		
Deductible per family	None	Not Covered		
Maximum per person	None	Not Covered		
Maximum per family	None	Not Covered	Per benefit period.	
Yearly maximum	None	Not Covered		
Lifetime maximum	\$1,000,000	Not Covered		
Formulary	Multi-tier	Not Covered		
Retail	Covered	Not Covered	30-day supply.	
Tier 0	Not Covered	Not Covered		
Tier 1	\$10	Not Covered		
Tier 2	\$20	Not Covered		
Tier 3	\$35	Not Covered		
Specialty Drugs (Tier 5)	Not Covered	Not Covered		
Mail order	Covered	Not Covered	Up to a 90-day supply.	
Tier 0	Not Covered	Not Covered		
Tier 1	\$20	Not Covered		
Tier 2	\$40	Not Covered		
Tier 3	\$70	Not Covered		
Oral contraceptives	Covered	Not Covered		
Exclusive Home Delivery	No	Not Covered		

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Select Home Delivery	Yes	Not Covered	Participants are required to make a choice about their maintenance prescription drugs. Participants will have 2 fills at the retail pharmacy and then be required to contact Express Scripts with a decision on their third fill to continue through the retail pharmacy or switch to a mail order program.	8/1/2010
Mandatory generic prescription drugs	Yes	Not Covered		
Quantity limits	Yes	Not Covered	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Yes ; 20% up to \$1,000 maximum	Not Covered	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Metabolic Supplement	Yes	Not Covered	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Yes	Not Covered	The program requires the use of a first step drug(s) before use of a 2nd or 3rd step drug.	
Prior Authorization	Yes	Not Covered	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Flu/Pneumonia/H1N1 Vaccine Program	Yes	Not Covered	Flu vaccines are provided and administered by pharmacists contracted to administer vaccines.	
Weight loss drugs	Not Covered	Not Covered		
Other	Yes	Not Covered	oral and injectible infertility drugs are not covered. Erectile dysfunction drugs are not covered.	
Mental Health				
Inpatient services	20%	40%	Unlimited days	8/1/2010
Outpatient services	20%	40%	Unlimited visits.	8/1/2010
Substance Abuse				
Outpatient services	20%	40%	Unlimited visits.	8/1/2010
Detoxification	20%	40%	Unlimited visits.	8/1/2010
Inpatient Non-hospital residential substance abuse treatment	20%	40%	Unlimited Days.	8/1/2010
Mental Health/ Substance Abuse				

Participant Responsibility

	Preferred*	Non-Preferred**	Limitations/ Non-Standard	Benefit Change Date/ Non-Standard Change Date
Outpatient emergency room visit	\$30	\$30	Not subject to deductible. Copayment waived if admitted.	8/1/2010
Ambulance services, emergency transport	0%	0%	Preferred not subject to deductible. Non-preferred participant maybe liable for charges that exceed the allowable charge. ¹	8/1/2010
Ambulance services, non-emergency transport	20%	20%	Non-preferred participant maybe liable for charges that exceed the allowable charge. ¹	8/1/2010

Exclusions

Please see attached

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

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

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

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

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

**BlueCare PPO
Plan Specific Exclusions**

This amends the Administrative Service Agreement BlueCare PPO Plus as follows:

EXCLUSIONS is amended by adding the Plan Specific Exclusions as indicated below:	Exclusion Change Date
1. Services which are not Medically Necessary, except those that are provided within the Policy for preventive services or those mandated by law.	8/1/2010
2. Any service in connection with or required by a procedure not set forth in the foregoing Description of Covered Services Section, except as necessitated by subsequent complications.	
3. Services in excess of any Benefit Maximum as stated.	
4. Charges for services or supplies incurred prior to the Participant's Effective Date.	
5. Except as provided by the Plan, charges for services or supplies incurred after the date of termination of the Participant's coverage.	
6. Charges, which exceed the Allowable Charge.	
7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.	
8. Services which First Priority Life initially determines are Experimental or Investigative; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative. Coverage will not be provided for services related to medical research.	
9. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation; or losses sustained or expenses incurred as a result of act of war whether declared or undeclared.	
10. Treatment or services received as a result of the Participant's participation in a riot or insurrection.	
11. Services as a result of injuries sustained during the Participant's commission of or attempt to commit a felony.	
12. Services for which an Participant would have no legal obligation to pay.	
13. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from Surgery.	
14. The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy; otoplasty; rhytidectomy; blepharoplasty; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following a Mastectomy; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.	
15. Treatment of temporomandibular joint (TMJ) or myofascial (MPD) pain dysfunction or craniomandibular (CMD) pain syndrome, including surgical and non surgical exam, invasive and non invasive procedures and tests, and all related medical and surgical services. Examples of non-Covered Services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.	
16. With respect to the extraction of partially or totally bony impacted wisdom teeth: <ul style="list-style-type: none">• Hospital and Ambulatory Surgical Facility services are not covered, except if authorized by a Medical Director of First Priority Life as set forth in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 3.• General anesthesia charges are not covered, except as indicated in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 3 With respect to all other dental procedures and oral Surgery, the following are excluded: <ul style="list-style-type: none">• Removal of natural teeth, except when removal of teeth is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations.	8/1/2010

- All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injuries to the jaws, natural teeth, mouth or face. Chewing or biting shall not be considered an accidental injury.
 - Dental appliances, including, but not limited to dentures and bridges, except for the primary restoration following facial/dental trauma or when an integral part of a cleft palate repair.
 - Periodontics, endodontics, and orthognathic Surgery.
 - Dental implants
 - Treatment of diseases of the teeth or gums, including, but not limited to treatment of dental cavities.
 - Periodontics, endodontics, and orthognathic Surgery.
 - Orthodontics, except orthodontic treatment related to cleft palate repair as described in Section DB – Description of Covered Services, Subsection D, Surgery, Paragraph 1.
 - Dental care including repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue only.
 - Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures unless such procedures were for the treatment of accidental bodily injury.
- 17 Services for which Covered Services are available under Medicare or other governmental program, except Medicaid, a state or federal workers' compensation, employer's liability or occupational disease law or services provided by a member of the covered person's Immediate Family.
- 18 Charges to the extent payment has been made under Medicare when Medicare is the primary carrier or by any other federal, state, or local government program.
- 19 · Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD under the Agreement and for Participants age twenty-one (21) and over.
- Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in Section DB – Description of Covered Services.
 - Treatment of Autism Spectrum Disorder through the use of Chelation Therapy.
 - Any services listed in an Individual Education Plan (IEP) are not covered.
- 20 Mental health care and/or Substance Abuse services rendered in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- 21 Services for the treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders without a known physical basis or due to a general medical condition.
- 22 Mental health care services for the treatment of Mental or Nervous Disorders, which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, including, but not limited to: anti-social personality, conduct disorders and paraphilias.
- 23 Substance Abuse services utilizing methadone or methadone-like equivalents.
- 24 Biofeedback/neurofeedback.
- 25 Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.
- 26 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.
- 27 Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.
- 28 Custodial care, domiciliary care, convalescent care, or rest cures, or specialized nursing care.

- 29 Physical, psychiatric or psychological examinations, testing, reports, vaccinations, immunizations or treatments, when such services are: (a.) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (b.) relating to judicial or administrative proceedings or orders; (c.) conducted for purposes of medical research; or (d.) to obtain or maintain a license of any type.
- 30 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.
- 31 Charges for the surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.
- 32 Charges for chiropractic care
- 33 Charges for treatment or services by a chiropractor
- 34 Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except those providing at least thirty-five (35) percent of daily caloric requirements given enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take nutrition by mouth, or in conditions of gastrointestinal tract impairment, parenterally through an intravenous catheter. Infant formulas including those prescribed for reasons of fat malabsorption, lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic Formulas, except those that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
- 35 The purchase of organs, which are sold rather than donated to transplant recipients, and charges for organ donor searches are also excluded from coverage.
- 36 Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law or any applicable federal or state law. This exclusion applies regardless of whether the Insured claims the benefit compensation.
- 37 Long-Term Residential Care.
- 38 Outpatient cognitive rehabilitation services have been determined by First Priority Life not to be Medically Necessary and appropriate for the treatment of brain injury and are not covered by this Policy.
- 39 Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.
- 40 Pulmonary Rehabilitative Therapy on an Inpatient basis.
- 41 Transsexual Surgery and treatment and services in support of transsexual Surgery, except for treatment resulting from a complication of such transsexual Surgery.