BlueCare Traditional

Administrative Services Agreement

Part 1 - Outline of Coverage

Company Name:	Northern Tier Insurance Consortium (NTIC) Blast Intermediate Unit 17	**Group Number(s):**	014422000, 014423000
Company Code:	200210	**Dependent/Student Age Limit:**	
Effective Date:	7/1/2014	**New Born Children:**	31 days
Renewal Date:	7/1/2015	**Full-time student leave of absence:**	Covered
Date - Part II Benefit Schedule:	7/1/2014	**Domestic Partners:**	Not Covered
Revision Date:	5/12/2014	**Credit (initial benefit period only)**	
Grandfathered Status	No	**Claims Appeal Fiduciary**	
NIA Services	No	**Benefit Period**	Calendar Year

FACILITY SERVICES	**Participant Responsibility**	**Limitations/ Non-Standard**	**Benefit Change/Customized Benefit Change Date**
Deductible	None		
Total Individual Maximum Out-of-Pocket	$6,350	Combined coverage with Hospital, Medical/ Surgical and Major Medical. Includes: Deductibles, Copayments (medical only), and Coinsurance amounts unless otherwise noted. Excludes: Penalties for failure to obtain Pre-Certification, charges in excess of the allowed amounts, charges for non-covered services and charges after Covered Medical Expenses have been exhausted.	7/1/2014
Total Family Maximum Out-of-Pocket	$12,700	Combined coverage with Hospital, Medical/ Surgical and Major Medical. No one person pays more than the individual amount and no family pays more than the aggregate family amount. Includes: Deductibles, Copayments, (medical only), and Coinsurance amounts unless otherwise noted. Excludes: Penalties for failure to obtain Pre-Certification,charges in excess of the allowed amounts, charges for non-covered services and charges after Covered Medical Expenses have been exhausted.	7/1/2014
Inpatient Copayment	No Copay		
Inpatient hospital services, including maternity	0%	unlimited	
Skilled nursing care	0%	60 days per Benefit Period.	
Transplants	0%		
Non-contracting Provider Coinsurance	30%	Allowable Charge[1]	
Precertification Penalty (facility)	$500	Late Precertification to a Non-contracting provider.	
Other Services			
Artificial Insemination	0%	3 attempts per lifetime	
Autism Spectrum Disorders	0%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $40,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Elective Abortions	Not Covered		
Emergency Medical/Accident Care	0%		
Newborn children	0%		
Ambulance (contracting provider), emergency	0%		
Ambulance (contracting provider), non-emergency	0%		

Ambulance (non-contracting provider), emergency	0%	The participant is responsible for amounts in excess of the allowable charge, when using providers who are not FPLIC participating or who are not Blue Card participating.	
Home Infusion Therapy	0%		
Home Health services	0%	unlimited visits.	
Hospice care	0%	180 day lifetime maximum	
Morbid Obesity	0%	Surgery and medically necessary panniculectomies for participants 18 years or older who has no prior medical history of bariatric surgery; 1 morbid obesity procedure and 1 panniculectomy covered per lifetime. $2,000 copay per procedure for medically necessary Gastric Bypass Procedures. $1,000 copay per procedure for medically necessary panniculectomies.	
Radiation and chemotherapy	0%		
Dialysis	0%		
Inpatient Rehabilitation	0%	45 days per benefit period.	
Outpatient Cardiac Rehabilitation	Not Covered		
Outpatient Pulmonary Rehabilitation	Not Covered		
Outpatient Respiratory Rehabilitation	Not Covered		
Outpatient Diabetes Education	0%		
Therapeutic Drugs which are not self adminstrable	0%		
Sterilization (Tubal)	0%	Sterilization reversals not covered.	
Sterilization (Vasectomy)	0%	Sterilization reversals not covered. Inpatient are not covered.	
Clinical Trials	0%		7/1/2014
Mental Health/Substance Abuse Services			
Inpatient mental health services	0%	Unlimited inpatient.	
Inpatient Non-hospital residential substance abuse treatment	0%	Unlimited days.	
Substance Abuse Detoxification	0%	Unlimited days.	
Outpatient substance Abuse services	0%	Unlimited visits.	
Outpatient emergency room visit	0%		
Ambulance (contracting provider), emergency	0%		
Ambulance (contracting provider), non-emergency	0%		
Ambulance (non-contracting provider), emergency	0%	Participants maybe liable for charges that exceed the allowable charge.	
Professional Services			
Deductible	None		
Total Individual Maximum Out-of-Pocket	$6,350	Combined coverage with Hospital, Medical/ Surgical and Major Medical. Includes: Deductibles, Copayments (medical only), and Coinsurance amounts unless otherwise noted. Excludes: Penalties for failure to obtain Pre-Certification, charges in excess of the allowed amounts, charges for non-covered services and charges after Covered Medical Expenses have been exhausted.	7/1/2014

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Non-contracting Provider Coinsurance	30%	Allowable Charge [1]	
Inpatient Physician Visits	0%	unlimited	
Autism Spectrum Disorder	0%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $40,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Allergy Testing	0%		
Maternity	0%		
Newborn children	0%		
Bony Impacted Wisdom Teeth	50%	In-network coverage only.	
Chemotherapy	0%		
Cosmetic	Not Covered		
Outpatient Diabetic Education	0%		
Diagnostic Medical	0%		
Diagnostic Pathology	0%		
Dialysis	0%		
Emergency Medical/Accident Care	0%		
Hearing	Not Covered		
Routine physical exams	0%	Routine exams are preventive medical evaluations and management exams.	
Outpatient Physical Therapy	0%		
Outpatient Respiratory Therapy	Not Covered		
Psychiatric inpatient visits	0%		
Routine gynecological exam and pap smear	0%		
Childhood Immunizations	0%		
Routine Mammography /diagnostic	0%		
Routine colorectal cancer and prostate cancer screening	0%		
Neonatal Circumcisions	0%		
Skilled nursing facility care	0%		
Second surgical opinion	0%	Limited to one (1) consultation per consultant.	
Surgery - Assistant Surgery	0%		
Theraeutic Drugs which are not self administrable	0%		
Infertility	0%	Diagnostic services leading up to the diagnosis of infertility.	
Invitro Fertilization	Not Covered		
Artificial Insemination	0%	3 attempts per lifetime	
Sterilization (Tubal)	0%	Sterilization reversals not covered.	
Sterilization (Vasectomy)	0%	Sterilization reversals not covered. Inpatient are not covered.	
Clinical Trials	0%		7/1/2014

Major Medical Services			
Annual Deductible per person	$50	Per Benefit Period. Deductible must be met first prior to claim payment.	
Annual Deductible per family	$150	Maximum 3 separate deductibles per family, per Benefit Period. Deductible must be met first prior to claim payment.	
Coinsurance	20%	Allowable Charge [1]	
Annual coinsurance maximum per person	$200	Per Benefit Period.	
Annual coinsurance maximum per family	$600	Maximum 3 separate coinsurance maximums per family, per Benefit Period.	
Total Individual Maximum Out-of-Pocket	$6,350	Combined coverage with Hospital, Medical/ Surgical and Major Medical. Includes: Deductibles, Copayments (medical only), and Coinsurance amounts unless otherwise noted. Excludes: Penalties for failure to obtain Pre-Certification, charges in excess of the allowed amounts, charges for non-covered services and charges after Covered Medical Expenses have been exhausted.	7/1/2014
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Lifetime Maximum	Unlimited		
Ambulance	Not Covered	Emergency/ Non-emergency	
Autism Spectrum Disorder	20%	Diagnosis and treatment of Autism Spectrum Disorders (ASD) for children under age 21 limited to $40,000. Combined coverage with Hospital, Medical/ Surgical and Major Medical. Coverage is subject to any applicable copays, coinsurance, and/or deductible.	
Cardiac Rehabilitation	20%	36 visits per Benefit Period.	
Chiropractic manipulative benefits	20%	20 visits per Benefit Period, ages 13 and up. All services billed by a chiropractor are applied to the chiropractic benefit.	
Durable medical equipment, prosthetics, & orthotics	20%	Unlimited maximum	
Ostomy supplies	50%	Ostomy appliances and supplies specifically relating to an ostomy. Limited to collection devices, irrigation equipment and supplies, skin barriers and skin protectors; and urinary catheters, both reusable or disposable, whether or not used in conjunction with an ostomy. Covered up to $1,000 maximum per participant per benefit period. Amounts are applied to coinsurance maximum but will always pay at coinsurance amount. In network only.	
Outpatient Dialysis	Not Covered		
Home Infusion Therapy	Not Covered		
Non-Contracting Provider Balances	Not Covered		
Nutritional Therapy	0%	6 visits per member per benefit period. Not subject to deductible.	
Oupatient Physician sick office visits	20%	Sick visits must have diagnosis.	
Outpatient Occupational Therapy	20%	12 visits per Benefit Period.	
Outpatient Pulmonary Rehabilitation	20%	18 visits per Benefit Period.	
Outpatient Respiratory Therapy	20%	18 visits per Benefit Period.	
Outpatient Physical Therapy	20%	20 visits per Benefit Period.	
Outpatient Speech Therapy	20%	12 visits per Benefit Period.	
Prescription Drugs	Not Covered		
Private Duty Nursing	Not Covered		
Retail clinic care	20%		

Therapeutic Drugs which are not self administrable	Not Covered		
Outpatient Mental Health services	0%	Not subject to deductible.	
Urgent Care	20%		
Private Room Allowance	Not Covered		
Clinical Trials	20%		7/1/2014
Prescription Drugs			
Deductible per person	$50		
Deductible per family	$150	Three members must meet the individual deductibles in order to satisfy the family deductible per benefit period.	
Maximum per person	$200		
Maximum per family	$600	Three members must meet the individual maximum in order to satisfy the family maximum per benefit period.	
Yearly maximum	None		
Lifetime maximum	None		
Formulary	Multi-tier		
Retail	Covered	30-day supply.	
Tier 0	Does not Apply		
Tier 1	20%		
Tier 2	20%		
Tier 3	20%		
Tier 5 (Specialty Drugs)	Does not Apply		
Mail Order	Covered	Up to a 90-day supply.	
Tier 0	Does not Apply		
Tier 1	20%		
Tier 2	20%		
Tier 3	20%		
Contraceptives	Covered	Excluding non-drug containing devices	
Exclusive Home Delivery	Does not Apply		7/1/2014
Select Home Delivery	Applies	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.	
Generics Preferred	Does not Apply		
Quantity Management Limits	Applies	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Applies	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Metabolic Supplement	Covered	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Applies	The program requires the use of a first step drug(s) before use of a 2nd or 3rd step drug.	
Prior Authorization	Applies	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Vaccine Program	Applies	Vaccines are provided and administered by pharmacists contracted to administer vaccines.	
Weight Loss Drugs	Not Covered		

2010 Preventive Schedule	Applies		
2012 Preventive Schedule	Applies		

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 contracting provider as payment in full for covered services less any deductibles, coinsurance, copayments, and amounts exceeding any benefit maximums. For a non-contracting provider, the allowable charge is the same amount First Priority Life would pay to a contracting provider. Non-contracting providers may balance bill the participant.

* Coverage described in this column applies when services are performed by Participating Providers, or are otherwise in accordance with network rules. Non-contracting providers will reduce to the coinsurance indicated for all facility charges.

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

Indemnity

Standard Exclusions

This amends the Administrative Service Agreement Indemnity as follows:

	EXCLUSIONS is amended by adding the Standard Exclusions as indicated below:	**Exclusion Change Date**
	A. Except as may be specifically provided in the Covered Services, the following are not covered under the Agreement:	
1	Services which are not Medically Necessary, except those that are provided within the Agreement 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 Service Section, except as necessitated by subsequent complications.	
3	Services in excess of any Benefit Maximum as stated in Section DB – Description of Covered Services.	
4	Charges for services or supplies incurred prior to the Participant’s Effective Date.	
5	Covered Services After Termination of Coverage, 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.	
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 a 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; the treatment of 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 TMJ is excluded except for surgical treatment for the total reconstruction or replacement of a completely degenerated joint.	7/1/2014
16	With respect to the extraction of partially or totally bony impacted wisdom teeth: • Hospital and Ambulatory Surgical Facility services are not covered, except if authorized by a Medical Director of First Priority Life as set forth in Section DB – Description of Benefits, 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: • Removal of natural teeth, except when removal of teeth is a part of a broader treatment plan related to diseases and injuries of the jaw, head and neck, fractures and dislocations • All dental services including diagnostic, preventive and primary dental care related to the care or filling of natural teeth, regardless where or by whom performed, except if required as a result of accidental injury 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. • 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	Charges to the extent payment has been made under Medicare or when Medicare is the primary carrier, or under another governmental program, except Medicaid.	
18	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.	
19	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 Participants claims the benefit compensation.	
20	The following, applicable to the treatment of Autism Spectrum Disorder: • 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 benefits provided in Section DB – Description of Covered Services. • Treatment of Autism Spectrum Disorder through the use of Chelation Therapy. • Treatment of Autism Spectrum Disorder through therapeutic day treatment and/or summer camp. • Any services listed in an Individual Education Plan (IEP) are not covered.	
21	Services for the treatment of anti-social personality, conduct disorders and paraphilias.	
22	Methadone or methadone-like equivalents (except for Suboxone equivalents and Subutex equivalents.)	
23	Biofeedback/neurofeedback.	
24	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.	
25	Routine and cosmetic foot care, except for care provided as certified Medically Necessary for children due to the growth process or for care provided as a result of diabetes.	
26	The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes.	
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, Private Duty Nursing or specialized nursing care.	
29	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.	

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	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 that provide 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.	
32	The purchase of organs, which are sold rather than donated to transplant recipients, and charges for organ donor searches are also excluded from coverage.	
33	Long-Term Residential Care.	
34	Outpatient cognitive rehabilitation services which have been determined by First Priority Life not to be Medically Necessary and appropriate for the treatment of brain injury.	
35	Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.	
36	Pulmonary Rehabilitative Therapy on an Inpatient basis.	
37	Reversal of voluntary sterilization.	
38	Transsexual Surgery and treatment and services in support of transsexual surgery, except for treatment resulting from a complication of such transsexual Surgery.	
39	Charges in connection with penile implants.	
40	Abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest.	
41	Separate charges by interns, residents, and other health care professionals who do not have a Provider Agreement with First Priority Life, who are directly, or indirectly employed by a Hospital or Facility Other Provider which makes their services available.	
42	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.	
43	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.	
44	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.	
45	Charges for telephone calls or telephone consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.	
46	Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.	
47	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, menatropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.	

48	Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise determined by First Priority Life to be non-standard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, or prosthetic socks, except when administered by a home health agency as part of the home health benefit or as provided in Section DB – Description of Benefits, Subsection X, Diabetes education/Equipment/Supplies or Subsection EE, Ostomy Supplies; (d) exercise equipment; (e) self help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of Durable Medical Equipment, Prostheses and Orthoses; (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) or intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in Section DB – Description of Covered Services, Subsection, Surgery; (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) proglide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; and (v) modification or customization of any Durable Medical Equipment.	
49	Examinations for the prescription, fitting or adjustment of hearing aids.	
50	Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in Section DB – Description of Benefits, Subsection Z, Ambulance Services or immunizations for the purpose of travel.	7/1/2014
51	Services performed by a Provider with the same legal residence as a Participant or who is a family member, including spouse, brother, sister, parent or child.	
52	Services of Immediate Family or persons of the Participant's household.	
53	Alternative and complementary medicine, except as provided in Section CC – Care Coordination, Subsection I, Case Management.	
54	Adult circumcision in the absence of disease.	
55	Charges for a private room when a Semi-Private Room is available.	
56	Services, which are not prescribed, performed or directed by a Provider licensed to do so.	
57	Educational classes, support groups and disease management programs unless sponsored or provided by First Priority Life or required for diabetes education services and those that are mandated to be covered by law.	
58	Unattended Services.	
59	Take-home drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider; injectable or implantable contraceptive drugs and devices that are not self-administrable (except when used for an approved medical condition other than contraception) and fertility drugs regardless of use; drugs in certain drug classes specifically designated by First Priority Life as Specialty Drugs including, but not limited to: self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives unless provided in connection with covered transplants, monoclonal antibodies, and other biotech drugs; except those drugs administered by a Preferred Professional Provider that are not self-administrable and/or that are provided incident to a Covered Service; those drugs that are mandated to be covered by law; and/or which are covered under Section Rx – Prescription Drug Coverage, when coverage is provided for Prescription Drugs. (The Outline of Coverage specify whether Prescription Drug coverage applies.)	
60	Copayments, Deductibles, Coinsurance or penalties applied under the Plan.	
61	Screenings, other than those specifically listed on the preventive schedule or recommended by the U.S. Preventive Services Task Force (USPSTF).	
62	Charges in connection with surrogate parenting.	7/1/2014