

## Members Health Plan NJ - Summary Plan Description Changes

Members Health Plan NJ is changing its third-party administrator to Aetna and is therefore issuing new Summary Plan Descriptions (SPD) for all Plans for all enrolled groups effective January 1, 2020. The attached Summary of Material Modifications (SMM) outlines the material changes being made. This SMM may not include all changes. It is important for you to review the new Summary of Benefit Coverage (SBC), Benefit Summary and the Schedule of Benefits in the SPD for the Plan you are enrolled in.

For a copy of the new SPD, SBC or Benefit Summary please go to [www.membershealthplannj.com](http://www.membershealthplannj.com) or you may contact us directly to request a hard copy at 1-833-MEWANOW, Option 7.

### Effective January 1, 2020 for all January and April renewal groups:

- I. The Plan will be changing networks from the QualCare Network in NJ and the Cigna Open Access POS network nationally to the Aetna Network(s) nationally. The Community Care Network will be replaced by the Aetna Whole Health NJ – Aetna Select Multi-Tier Network.
- II. The Out-of-Network elective and non-emergent services allowable charge has changed to the following benefit: For all Out-of-Network elective and non-emergent services, the Plan's Allowable Charges will be 110% for Professional services and 140% for facilities of current year Medicare/RBRVS.
- III. The In-Network Office Based or Free-Standing Lab services benefit has changed to the following benefit: PCP copay or cost share will apply for any In-Network Lab service.
- IV. The Pediatric Vision benefit has changed to the following benefit: Plan pays 100% up to \$125 maximum per year.
- V. The Plan's Telehealth vendor is changing from MDLIVE to TelaDoc. There are no changes to the way telehealth benefits will be paid.
- VI. The following individual benefit changes by Plan are as follows:

PLAN	CURRENT IN NETWORK BENEFIT	NEW IN NETWORK BENEFIT
<b>A</b>	Specialist visit: \$15 copay Emergency Room visit: \$50 copay Urgent Care visit: \$15 copay Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest) Max Out-of-Pocket: \$6,850 (individual) / \$13,700 (family) Inpatient Rehabilitation & Skilled Nursing: Plan pays 100%:	Specialist visit: \$75 copay Emergency Room visit: \$100 copay Urgent Care visit: \$75 copay Laboratory Services: \$15 copay (Office based or freestanding labs) Max Out-of-Pocket: \$4,000 (individual) / \$8,000 (family) Inpatient Rehabilitation & Skilled Nursing: Plan pays 100%, after \$250 per admission copay
<b>B</b>	Emergency Room visit: \$100 copay Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)	Emergency Room visit: After Deductible and \$100 copay/visit, Plan pays 90% (copay waived if admitted) Laboratory Services: \$30 copay (Office based or freestanding labs)
<b>D</b>	Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest) Outpatient Ambulatory Surgery (Freestanding Surgical Center): Plan pays 100%	Laboratory Services: \$15 copay (Office based or freestanding labs) Outpatient Ambulatory Surgery (Freestanding Surgical Center): Plan pays 100% after Facility Deductible

<b>F</b>	<p>Max Out-of-Pocket: \$6,850 (individual) /\$13,700 (family)</p> <p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p> <p>Inpatient Rehabilitation &amp; Skilled Nursing: Plan pays 100%, after \$300 copay</p>	<p>Max Out-of-Pocket: \$4,000 (individual) /\$8,000 (family)</p> <p>Laboratory Services: \$30 copay (Office based or freestanding labs)</p> <p>Inpatient Rehabilitation &amp; Skilled Nursing: \$500 copay per day x 5 days per admission, then Plan pays 100%</p>
<b>G</b>	<p>Emergency Room visit: \$100 copay</p> <p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p>	<p>Emergency Room visit: After Deductible and \$100 copay/visit, Plan pays 80% (copay waived if admitted)</p> <p>Laboratory Services: \$35 copay (Office based or freestanding labs)</p>
<b>H</b>	<p>Emergency Room visit: \$100 copay</p> <p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p>	<p>Emergency Room visit: \$100 copay/visit, then Plan pays 80% (copay waived if admitted)</p> <p>Laboratory Services: \$15 copay (Office based or freestanding labs)</p>
<b>J</b>	<p>Inpatient Rehabilitation &amp; Skilled Nursing: After deductible, Plan pays 90%</p> <p>Inpatient Admission: \$500 copay per admission</p> <p>Emergency Room visit: \$100 copay</p> <p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p>	<p>Inpatient Rehabilitation &amp; Skilled Nursing: After deductible, \$500 copay per admission, then Plan pays 90%</p> <p>Inpatient Admission: After deductible, \$500 copay per admission, then Plan pays 90%</p> <p>Emergency Room visit: After Deductible and \$100 copay/visit, Plan pays 90% (copay waived if admitted)</p> <p>Laboratory Services: \$30 copay (Office based or freestanding labs)</p>
<b>K</b>	<p>Max Out-of-Pocket: \$6,850 (individual) /\$13,700 (family)</p> <p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p>	<p>Max Out-of-Pocket: \$4,000 (individual) /\$8,000 (family)</p> <p>Laboratory Services: \$30 copay (Office based or freestanding labs)</p>
<b>L</b>	<p>Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)</p>	<p>Laboratory Services: \$50 copay (Office based or freestanding labs)</p>
<b>M</b>	<p>Outpatient Ambulatory Surgery - Facility/Hospital Charges (Tier 1): Hosp charges: \$50 copay, FSF: \$250 copay</p> <p>Chiropractic Care (Tier 2): \$50 copay/visit</p> <p>Laboratory Services (Tier 1): Plan pays 100% (Office Based or freestanding when using Quest)</p> <p>Rx Copays apply to Tier 2 Max Out-of-Pocket</p>	<p>Outpatient Ambulatory Surgery -Facility/Hospital Charges (Tier 1): \$250 copay then Plan pays 100%</p> <p>Chiropractic Care (Tier 2): After deductible, Plan pays 70%</p> <p>Laboratory Services (Tier 1): \$25 copay (Office based or freestanding labs)</p> <p>Rx Copays apply to Tier 1 Max Out-of-Pocket</p>
<b>N</b>	<p>RX 4 &amp; 5 Deductible applied to Tier 2</p>	<p>Rx 4 &amp; 5 Deductible applied to Tier 1</p>
<b>O</b>	<p>Outpatient Therapy Services -Facility/Hospital Based: \$50 copay/visit</p> <p>Inpatient Rehabilitation &amp; Skilled Nursing: After deductible, Plan pays 70%</p> <p>Emergency Room visit: \$100 copay</p> <p>Laboratory Services: 100% after deductible (Office Based or freestanding when using Quest)</p>	<p>Outpatient Therapy Services -Facility/Hospital Based: After deductible, Plan pays 70%</p> <p>Inpatient Rehabilitation &amp; Skilled Nursing: \$500 copay per admission; After Deductible, Plan pays 70%</p> <p>Emergency Room visit: After Deductible, \$100 copay, then plan pays 70%</p> <p>Laboratory Services: \$30 copay (Office based or freestanding labs)</p>
<b>P</b>	<p>Laboratory Services: 100% after deductible (Office Based or freestanding when using Quest)</p>	<p>Laboratory Services: \$50 copay (Office based or freestanding labs)</p>

<b>R</b>	Laboratory Services: 100% after deductible (Office Based or freestanding when using Quest)	Laboratory Services: \$25 copay after deductible (Office based or freestanding labs)
<b>S</b>	Laboratory Services: 100% after deductible (Office Based or freestanding when using Quest)	Laboratory Services: \$30 copay after deductible (Office based or freestanding labs)
<b>T</b>	In-Network Deductible: \$1,500 (individual) / \$3,000 (family) Max Out-of-Pocket: \$4,000 (individual) / \$8,000 (family) PCP visit: \$30 copay Specialist visit: \$60 copay Emergency Room visit: \$100 copay Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)	In-Network Deductible: \$2,000 (individual) / \$4,000 (family) Max Out-of-Pocket: \$6,850 (individual) / \$13,700 (family) PCP visit: \$35 copay Specialist visit: \$70 copay Emergency Room visit: After Deductible and \$100 copay/visit, plan pays 80% (copay waived if admitted) Laboratory Services: \$35 copay (Office based or freestanding labs)
<b>U</b>	Inpatient Rehabilitation & Skilled Nursing: After deductible, Plan pays 80% Emergency Room visit: \$100 copay Laboratory Services: Plan pays 100% (Office based or freestanding lab when using Quest)	Inpatient Rehabilitation & Skilled Nursing: \$500 per admission copay, after deductible, Plan pays 80% Emergency Room visit: After Deductible and \$100 copay/visit, Plan pays 80% (copay waived if admitted) Laboratory Services: \$30 copay (Office based or freestanding labs)
<b>V</b>	Laboratory Services: Plan pays 100% (Office Based or freestanding when using Quest)	Laboratory Services: After Deductible, Plan pays 100% (Office based or freestanding labs)
<b>W</b>	Laboratory Services: 100% after deductible (Office Based or freestanding when using Quest)	Laboratory Services: After Deductible, \$30 copay (Office based or freestanding labs)
<b>X</b>	TIER 2 Max Out-of-Pocket: \$6,600 (individual) / \$13,200 (family) Outpatient Ambulatory Surgery-Facility/Hospital Charges: (Tier 1): Hosp charges: \$50 copay, FSF: \$250 copay Chiropractic Care (Tier 2): \$50 copay/visit Emergency Room Services (Tier 1 & Tier 2): \$100 copay/visit, then \$500 Emergency Room deductible, then 100% (copay waived if admitted) Laboratory Services (Tier 1): Plan pays 100% (Office Based or freestanding when using Quest) Rx Copays apply to Tier 2 Max Out-of-Pocket	TIER 2 Max Out-of-Pocket \$6,000 (individual) / \$12,000 (family) Outpatient Ambulatory Surgery-Facility/Hospital Charges (Tier 1): \$250 copay then Plan pays 100%. Chiropractic Care (Tier 2): After deductible, Plan pays 50% Emergency Room Services (Tier 1 & Tier 2): \$100 copay/visit, then Plan pays 100% (copay waived if admitted) Laboratory Services (Tier 1): \$30 copay (Office based or freestanding labs) Rx Copays apply to Tier 1 Max Out-of-Pocket

Y	Allergy Injections and Allergy Test with Office Visit (Tier 1): After deductible, Plan pays 50%	Allergy Injections and Allergy Test with Office Visit (Tier 1): After deductible, \$50 copay/visit
	Outpatient Ambulatory Surgery-Facility/Hospital Charges: (Tier 1): Plan pays 50%, after \$50 copay, after deductible	Outpatient Ambulatory Surgery-Facility/Hospital Charges: (Tier 1): Plan pays 50%, after \$250 copay, after deductible
	Urgent Care Center (Tier 1 & 2): \$50 copay	Urgent Care Center (Tier 1 & 2): After deductible, \$50 copay
	Inpatient Care (Facility/Hospital charges), Inpatient Rehabilitation & Skilled Nursing Care, and Inpatient/Residential Treatment Facility (Tier 1): \$500 copay per day x 5 days per admission, then Plan pays 50%	Inpatient Care (Facility/Hospital charges), Inpatient Rehabilitation & Skilled Nursing Care, and Inpatient/Residential Treatment Facility (Tier 1): After Deductible, \$500 copay per day x 5 days per admission
	Laboratory Services (Tier 1): Plan pays 100% (Office Based or freestanding when using Quest)	Laboratory Services (Tier 1): After Deductible, \$30 copay (Office based or freestanding labs)
Rx Copays apply to Tier 2 Max Out-of-Pocket	Rx Copays apply to Tier 1 Max Out-of-Pocket	
Z	None	New Plan: AWH Network Only Low (Silver)

**VII. For all Enrolled Groups, Section titled “Confidentiality/HIPAA Privacy”, the following changes are reflected in the new Summary Plan Description:**

The following provisions relate to the Plan’s handling of personal health information (PHI).

**Protected Health Information**

PHI is information that relates to an individual’s health, healthcare, treatment, or payment for Healthcare that identifies the individual. Identification may be by name, social security number or similar information that relates to a specific individual. Information related to Your past health, present health, treatment, diagnosis or Conditions is considered to be PHI.

The Plan must comply with applicable requirements under Federal Regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. The Plan will communicate PHI to the Plan Sponsor as necessary to administrate the Plan including obtaining premium bids, modifying, amending or terminating the Plan. PHI may only be accessed by Plan Sponsor employees or delegated administrators as required for the proper administration of the Plan.

Permitted uses and disclosures of PHI by the Plan Sponsor shall provide for the following:

- 1) The Plan Sponsor will not use or further disclose PHI, except as permitted by the Plan documents or as required by law, and, if applicable, report to the Plan any improper disclosures.
- 2) The Plan Sponsor will not use the information for any employment-related action or in connection with any other benefit plan.
- 3) The Plan Sponsor will allow individuals access to their own PHI, consider their amendments, and, upon request, provide an accounting of the disclosures made.
- 4) The Plan Sponsor will ensure its agents and subcontractors agree to similar restrictions.
- 5) The Plan Sponsor will make its internal practices and records available to the HHS.
- 6) If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan when such information is no longer needed.

**VIII. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Covered Newborn Child, the following changes are reflected in the new Summary Plan Description:**

The Plan covers charges for the Child’s routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

- 1) Nursery charges;
- 2) Charges for routine Practitioner’s examinations and tests; and
- 3) Charges for routine procedures, such as circumcision.

Subject to all of the terms of this Plan, the Plan covers the care and treatment of a covered newborn Child if he or she is ill,

Injured, premature, or born with a congenital birth defect.

*Note: Newborn Children must be enrolled in the Plan within 60 days in order to be covered by the Plan. Please contact Your Employer to submit an enrollment form to the Plan Administrator.*

**IX. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Dental Services, the following changes are reflected in the new Summary Plan Description:**

This Plan also covers charges for the treatment of Injury to sound natural teeth or the jaw that are Incurred within 12 months after the accident. But this is only if the Injury was not caused, directly or indirectly, by biting or chewing and all treatment is finished within 6 months of the later of:

- 1) the date of the Injury; or
- 2) the effective date of the Covered Person’s coverage under this Plan.

Treatment includes replacing sound natural teeth lost due to Injury. But it does not include orthodontic treatment.

**X. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Donated Human Breast Milk, the following changes are reflected in the new Summary Plan Description:**

Donated human breast milk will be covered based on Medical Necessity and Appropriateness for those applicable recipients. Breast milk donation is not covered by the Plan. A US federal government certified Human Breast Milk bank must be utilized.

The Plan covers pasteurized donated human breast milk for Covered Persons under the age of six months subject to the following conditions:

- a) The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person’s mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
- b) The Covered Person’s Practitioner issued an order for the donated human breast milk.

The Plan also covers pasteurized donated human breast milk as ordered by the Covered Person’s Practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

- a) A body weight below healthy levels determined by the Covered Person’s Practitioner;
- b) A congenital or acquired Condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
- c) A congenital or acquired Condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the New Jersey Department of Health. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person’s Practitioner.

**XI. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Hospital Services, the following changes are reflected in the new Summary Plan Description:**

Except as stated below, the Plan covers charges for Inpatient care for:

- 1) a minimum of 72 hours following a modified radical mastectomy; and
- 2) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is Medically Necessary and Appropriate.

**XII. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Emergency and Urgent Care Services, the following changes are reflected in the new Summary Plan Description:**

Coverage for Emergency and Urgent Care includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgment of the attending Physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. The Plan also provides coverage for a medical screening examination provided upon a Covered Person’s arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical Condition exists.

Care Not Available Within the Network

You must obtain Medical Precertification from the Plan prior to receiving services and treatment in order to receive the In-

Network level of benefits through this special feature. This doesn't apply to Substance Use Disorders for the first 180 days of network treatment per Plan Year. The prospective determination of Medically Necessary and Appropriateness is made by the Covered Person's physician for the first 180 days of network treatment.

**XIII. For all Enrolled Groups, Section titled "Summary of Covered Services and Supplies", Skilled Nursing Care, the following changes are reflected in the new Summary Plan Description:**

Covered services include inpatient skilled nursing Facility care.

The types of skilled nursing Facility care services that are eligible for coverage include:

- 1) Room and board, up to the semi-private room rate
- 2) Services and supplies that are provided during Your stay in a skilled nursing Facility

The Plan provides combined coverage for skilled care, extended care and rehabilitation services for a combined sixty (60) days for each Condition per Plan Benefit Year. The Plan does not cover charges for any additional days.

Charges which are in excess of sixty (60) days per Condition maximum per Plan Benefit Year will not be considered as Covered Charges.

The Plan covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

- 1) start within 14 days of a Hospital stay; and
- 2) be due to the same or a related Condition that necessitated the Hospital stay.

**XIV. For all Enrolled Groups, Section titled "Summary of Covered Services and Supplies", Home Health Care Charges, the following changes are reflected in the new Summary Plan Description:**

Charges for Home Health Care provided by a Home Health Care Agency in the home, but only when all of the following criteria are met:

- 1) You are homebound.
- 2) Your Physician orders them and it's Medically Necessary and Appropriate services or supplies,
- 3) The services take the place of Your needing to stay in a Hospital or a skilled nursing Facility or needing to receive the same services outside Your home.
- 4) The services are a part of a Home Health Care plan.
- 5) The services are skilled nursing services, nutrition services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- 6) The supplies are medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Plan if the Covered Person had been in a Hospital; and
- 7) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Plan if performed as Inpatient Hospital services.
- 8) If You are discharged from a Hospital or skilled nursing Facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.
- 9) Home health aide services are provided under the supervision of a registered nurse.
- 10) Physician or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home.

Home healthcare services do not include custodial care.

Any visit by a member of a Home Health Care team on any day shall be considered as one Home Health Care visit. Benefits for Home Health Care are provided for no more than 60 visits per Benefit Plan Year.

**A penalty of 50% of the Plan's Allowable Charges to a maximum of \$10,000 will be applied if Medical Precertification is not obtained, provided that benefits would otherwise be payable under this Plan.**

Payment is subject to all of the terms of this Plan and to the following conditions:

- a) The Covered Person's Practitioner must certify that Home Health Care is needed in place of Inpatient care in a recognized Facility. Home Health Care is covered only in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if

Home Health Care were not provided.

- b) The services and supplies must be:
  - 1) ordered by the Covered Person's Practitioner;
  - 2) included in the Home Health Care plan; and
  - 3) furnished by, or coordinated by, a Home Health Agency according to the written Home Health Care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term (no more than three- day) basis.
- c) The Home Health Care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
- d) The Plan does not cover:
  - 1) services provided by an Out-of-Network Provider
  - 2) services furnished to family members, other than the patient; or
  - 3) services and supplies not included in the Home Health Care plan.
  - 4) charges by a Nurse for Medically Necessary and Appropriate Private Duty Nursing care, unless it is precertified as part of a Home Health Care Plan, coordinated by a Home Health Care Agency and covered under Home Health Care charges.

*Note: The Plan is not required to provide home health benefits if it determines that the treatment setting is not appropriate, or when a more cost-effective setting in which to provide Medically Necessary and Appropriate care is available.*

**XV. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Digital Tomosynthesis, the following changes are reflected in the new Summary Plan Description:**

The Plan covers charges for digital tomosynthesis to detect or screen for breast cancer and for diagnostic purposes as follows:

- 1) When used for detection and screening for breast cancer in a Covered Person age 40 years and older, the Plan covers charges for digital tomosynthesis as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.

When used for diagnostic purposes for a Covered Person of any age, the Plan covers charges for digital tomosynthesis as a diagnostic service subject to the applicable copayment, deductible and coinsurance.

**XVI. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Nutritional Counseling, the following changes are reflected in the new Summary Plan Description:**

The limit of 2 visits per year for Nutritional Counseling has been removed.

**XVII. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Therapy Services, the following changes are reflected in the new Summary Plan Description:**

The term "Developmental Disability" means a severe, chronic disability of a person which:

- a) is attributable to a Mental Disorders or physical impairment or combination of Mental Disorders or physical impairments;
- b) is manifested before age 26;
- c) is likely to continue indefinitely;
- d) results in substantial functional limitations in three or more of the following areas of major life activity, i.e., self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economical self- sufficiency; and
- e) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are not of a life-long or extended duration and are individually Planned and coordinated. Developmental Disability includes but is not limited to: severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

**XVIII. For all Enrolled Groups, Section titled “Summary of Covered Services and Supplies”, Transplant Benefits, the following changes are reflected in the new Summary Plan Description:**

This includes the following transplant types:

- 1) Solid organ
- 2) Hematopoietic stem cell
- 3) Bone marrow
- 4) Chimeric antigen receptor (CAR-T) and T-Cell receptor therapy for FDA approved treatments
- 5) Cornea

**XIX. For all Enrolled Groups, Section titled “Plan Exclusions”, the following changes are reflected in the new Summary Plan Description:**

**Foreign Travel.** Coverage for services and supplies provided outside the United States is not covered unless the Covered Person is outside the United States for one of the following reasons: (a) travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less; or (b) business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; (c) Subject to the Plan’s pre-approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by the Plan are Non-Covered Charges.

**XX. For all Enrolled Groups, Section titled “Plan Exclusions”, the following changes are reflected in the new Summary Plan Description:**

**Dose Intensive Chemotherapy.** The care and treatment by means of dose intensive chemotherapy is not covered unless as otherwise stated in this document.

**XXI. Prescription Benefit Change for Plans M, N, X, Y and Z:**

**Plan N.** Prescription deductible will apply to Tier 1 deductible and maximum out of pocket.

**Plans M, X, Y & Z.** Prescription copays will apply to Tier 1 maximum out of pocket.