Members HealthPlan NJ

SUMMARY PLAN DESCRIPTION

For Plans Effective as of July 1, 2019

Affiliated Physicians and Employers Master Trust ("Trust") has established a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Trust is licensed in the state of New Jersey as a multiple Employer welfare arrangement ("MEWA"). The Trust will offer benefit plans to members (Employers) as defined in the Plan's Underwriting Guidelines for medical, prescription drug and dental benefits. The Trust's benefit plans will be marketed as Members Health Plan NJ ("Plan").

By signing below, the Trust agrees to be bound by the terms of the described health care plan.

AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

By:

Authorized Representative

Witnessed:

By:

Date:

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INTRODUCTION

THE PLAN

The Plan Document consists of:

1) this document; and
2) the Plan's Underwriting Guidelines as of the Effective Date; and
3) the Health Plan Participation Request/Contract (available upon request); and
4) any riders, or amendments to this Plan (available upon request); and
5) any Summary Plan Descriptions for supplemental benefits, including Dental benefits, if purchased; and
6) the individual enrollment forms (available upon request), if any, of the Covered Persons.

STATEMENTS

No statement will void the coverage under this Plan, or be used in defense of a claim hereunder unless:

1) in the case of the Participating Employer, it is contained in the application signed by the Participating Employer; or
2) in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person.

All statements will be deemed representations and not warranties.

This document provides the terms and conditions for eligibility and benefits. This document provides highlights about the Members Health Plan NJ (hereinafter the "Plan"). The Plan is being sponsored by the Affiliated Physicians and Employers Master Trust (hereinafter the "Trust"). This document is intended to be a comprehensive description of the participation requirements and available benefits under the Plan. Please keep it for Your reference. When it states, "Plan Document" or "Summary Plan Description" ("SPD"), it is referring to this document. Benefits of the Trust are provided through a Multiple Employer Welfare Arrangement ("MEWA"). A MEWA is an arrangement, recognized in both Federal and state law, whereby multiple Employers join to self-insure some or all the welfare benefits of their Employees.

This is **not an insured benefit plan**. The benefits described in this booklet or any rider attached hereto are **self-insured** by the Participating Employers.

This is a fully assessable benefit plan. In the event that the Trust is unable to pay its obligations, members the of the Trust shall be required to contribute on a pro rata earned contribution basis the funds necessary to meet any unfulfilled obligations.

Third party administrative services are provided by Aetna Life Insurance Company ("Aetna"), its affiliates, or third party vendors under contract with Aetna.

AMENDMENT

The Trust reserves the right to change, modify and amend the Plan at any time and from time-to-time, in whole or in part, as well as any or all the provisions of the Plan, without advance notice subject to any outstanding contractual agreements or requirements of law. Any amendments to the Plan may be affected by a written resolution adopted by the Trust. Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like. An amendment will not affect benefits for a service or supply furnished before the date of the change.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Participating Employer or Covered Person(s) of a group engages in fraud or makes an intentional misrepresentation of a material fact or fails to report information, this may be used as the basis to rescind, terminate or modify the entire group's coverage or coverage for a particular Employee. Rescind means that the coverage was never in effect. The Plan will provide 60 days advance written notice to Employer and/or Employees who may be affected before coverage is rescinded.

If the Plan is terminated, the rights of Covered Persons are limited to Covered Charges incurred before termination. The Plan is administered within the purview of ERISA and the New Jersey Department of Banking and Insurance. Employers who are Participating Employers of the Trust are considered distinct legal entities from the Plan and the Trust.

This document summarizes the Plan's rights and benefits for covered Employees and their Dependent(s) and is divided into the following parts:

Eligibility Provisions. Explains eligibility for coverage under the Plan, and when the coverage takes effect and terminates.

Funding of Coverage. Explains how Plan is Funded.

Enrollment. Explains when coverage begins, ends and wen you can make changes.

Open Enrollment. Explains when you can enroll.

Plan Provisions. Explains how the plan works.

Summary of Covered Services and Supplies. Details what charges are covered.

Plan Exclusions. Details what charges are **not** covered.

Medical Management Services. The purpose of the program is to determine what is payable by the Plan and to curb any unnecessary and excessive charges.

This part should be read carefully since each Covered Person is required to take action to assure that the maximum payment levels under the Plan are paid.

Claims Decision and Appeal Procedures. Explains how claims are processed and appeal rights.

Continuation of Care. Explains the benefits if a Provider terminates from the network in the middle of treatment.

Coordination of Benefits. Explains the Plan payment order when a person is covered under more than one Plan.

Subrogation and Right of Recovery. Explains this Plan's right to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuing Coverage. Explains when a person's coverage under the Plan ceases and the continuation options are available.

Responsibilities for Plan Administration. Explains the responsibilities of the administrators of the Plan.

ERISA Rights. Explains the Plan's structure and Covered Persons' rights under the Plan.

Plan Administration Information. Contact information for administrators of the Plan.

Defined Terms. Defines those Plan terms that have a specific meaning.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

IMPORTANT INFORMATION

CONTACT INFORMATION

For questions related to the Plan administration or for enrollment/eligibility questions please contact Members Health Plan NJ at 1-(833) MEWANOW.

For questions related to benefit coverage, claims status and appeals, to find a participating provider and Medical Management or for Medical Precertification, please contact Aetna at the phone number on the back of Your ID Card.

NOTICE OF STATE REQUIREMENTS

The Affiliated Physicians and Employers Master Trust is not an insurance company and does not participate in any of the guarantee funds created by New Jersey Law. These funds will not pay Your claims or protect Your assets if the Trust becomes insolvent and is unable to make payments as promised.

The health care benefits that the Employer has purchased or is applying to purchase are being issued by a self-funded Multiple Employer Welfare Arrangement ("MEWA"), sponsored by the Trust and marketed as Members Health Plan NJ. The self-funded MEWA is required to maintain sufficient reserves to pay for all incurred losses including unpaid claims. It is important that You check with Your Employer to determine which, if any, state mandated health care benefits may be covered by Your arrangement.

For additional information about Your Plan, You should ask questions of Your Plan Administrator at 1-(833) MEWANOW.

NOTICE OF FEDERAL REQUIREMENTS

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the *Women's Health and Cancer Rights Act of 1998* (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1) All stages of reconstruction of the breast upon which the mastectomy has been performed,
2) Surgery and reconstruction of the other breast to produce a symmetrical appearance,
3) Prostheses, and
4) Treatment of physical complications of the mastectomy, including lymphedema.

If You would like more information on WHCRA benefits, please contact Your Plan with the phone number on Your ID card.

COVERAGE FOR MATERNITY HOSPITAL STAY

Group Health plans and health insurance issuers offering group health coverage generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain Medical Precertification from the Plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

Please review this Plan for further details on the specific coverage available to You and Your Dependents.

NOTICE REGARDING PROVIDER DIRECTORIES AND PROVIDER NETWORKS

Your Plan utilizes a network of Providers, and You can view them online at www.membershealthplannj.com or call Member Services at the phone number listed on the back of Your ID card. Your In-Network Provider network consists of a group of local Physicians, including Hospitals, of varied specialties as well as general practice, who are contracted with Aetna or the Plan.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If You were covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed services leave, whichever is shorter, if You pay any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active Employees. If the leave is longer than 30 days, the required contribution will be higher, but will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage available under COBRA Continuation Coverage.

Whether or not You elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day You return to active employment with the Employer if You are released under honorable conditions and You return to employment:

1) On the first full business day following completion of Your military service for a leave of 30 days or less;
2) Within 14 days of completing Your military service for a leave of 31 to 180 days; or
3) Within 90 days of completing Your military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans Administration to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continuous under this Plan. Eligibility Waiting Period (if any) will be waived as if You had been continuously covered under this Plan from Your original Effective Date of coverage. This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by Your military service, as determined by the VA. For complete information regarding Your rights under USERRA, contact Your Employer.

THE NONDISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits Employers and other entities covered by GINA Title II from requesting or requiring Genetic Information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Plan is asking that You not provide any Genetic Information when responding to a request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and Genetic Information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Eligible Dependent Children who are required to be enrolled in the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) may be enrolled midyear. Upon receipt of an order (from a court or from an administrative agency) requiring enrollment of an eligible Dependent Child, the **Covered Person** will be notified if the order constitutes a Qualified Medical Child Support Order (QMCSO) as required under Federal law.

For more information about QMSCOs, contact the Plan. Covered Persons and beneficiaries in the Plan may obtain a copy of the Plan's QMCSO procedures upon request and without charge.

MICHELLE'S LAW

This law affects all ERISA-qualified Plans and ensures that a Dependent college student requiring a medically necessary leave of absence from a postsecondary educational institution due to a serious Illness or Injury, can continue to receive coverage through their family's medical Plan even if they are unable to maintain their full-time student status. Written certification from a treating Physician must verify that the Dependent college student is suffering from a serious Illness or Injury and that the leave of absence is medically necessary. This law prevents a Group Health Plan from removing coverage from a "Dependent Child" due to a "medically necessary leave of absence" before the earlier of:

1) one year after the first day of the medically necessary leave of absence; or
2) the date on which the coverage under the Plan would otherwise terminate.

For these purposes, a "medically necessary leave of absence" means a leave of absence of a Child from a post-secondary educational institution or any other change in enrollment of such Child at such an institution that

1) commences while such Child is suffering from a serious illness or injury,
2) is medically necessary,
3) otherwise would cause such Child to lose student status for purposes of coverage under the terms of the Plan

SELECTION OF A PRIMARY CARE PHYSICIAN

This Plan does not require the designation of a Primary Care Physician (PCP) for enrollment. However, You have the right to designate any Primary Care Physician 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 Physician, and for a list of the participating Primary Care Physicians, visit www.membershealthplannj.com or contact Member Services at the phone number listed on the back of Your ID card.

For Children, You may designate a pediatrician as the Primary Care Physician.

DIRECT ACCESS TO OBSTETRICIANS AND GYNECOLOGISTS

You do not need Medical Precertification from the Plan or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from an In-Network Provider who specializes in obstetrics or gynecology. The In-Network Provider, however, may be required to comply with certain procedures, including obtaining Medical Precertification for certain services, following a pre-approved treatment plan, or procedures for making referrals, however,

the Covered Person will not be penalized if the In-Network Provider fails to follow the Plan rules. For a list of participating In-Network Providers who specialize in obstetrics or gynecology, visit www.membershealthplannj.com or contact Member Services at the phone number listed on the back of Your ID card.

CONFIDENTIALITY/HIPAA PRIVACY

The Trust and the Plan are committed to protecting confidential and Protected Health Information ("PHI") it collects from You or receives about You.

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.

Obligations of Plan Sponsor

The Plan Sponsor shall have the following obligations:

1) Ensure that any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; and
2) Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.
3) Not use or disclose protected health information received from the Plan:
   a) For employment-related actions and decisions; or
   b) In connection with any other benefit or Employee Benefit Plan of the Plan Sponsor.
4) Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.
5) Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a) For access to the individual;
   b) For amendment and incorporate any amendments to protected health information received from the Plan; and
   c) To provide an accounting of disclosures.
   d) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
6) Return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
7) Provide protected health information only to those individuals, under the control of the Plan Sponsor who perform administrative functions for the Plan; (i.e. eligibility, enrollment, payroll deduction, benefit Determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.
8) Provide protected health information only to those entities required to receive the information in order to maintain

the Plan (i.e. medical Claims Administrator, Medical Management Review Administrator, Pharmacy benefit manager, claim subrogation vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the Plan).

9) Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.
10) Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
    a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
    b) Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
    c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    d) Report to the Plan any security incident of which it becomes aware.

Exceptions

Notwithstanding any other provision of this HIPAA Privacy Section, the Plan may:

1) Disclose summary health information to the Plan Sponsor:
    a) If the Plan Sponsor requests it for the purpose of:
        i) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
        ii) Modifying, amending, or terminating the Plan;
2) 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 HMO offered by the Plan;
3) Use or disclose protected health information:
    a) With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
    b) To carry out treatment, payment, or health care operations in accordance with the privacy rule; or,
    c) As otherwise permitted or required by the privacy rule.

Your Right to File A Complaint

If You believe that Your privacy rights have been violated, You may complain to the Plan in care of the following officer:
William F. Megna
Privacy Official
Members Health Plan NJ
24 Arnett Avenue, Suite 115
Lambertville, NJ 08530
(609) 773-6150

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

The Plan will not retaliate against You for filing a complaint.

Whom to Contact for More Information

If You have any questions regarding this Notice or the subjects addressed in it, You may contact the following officer:
William Megna
Privacy Official
Members Health Plan NJ
24 Arnett Avenue, Suite 115
Lambertville, NJ 08530
609-773-6150

ELIGIBILITY PROVISIONS

ELIGIBLE PARTICIPANTS

Subject to the **conditions of Eligibility** set forth below, and to all of the other conditions of this Plan, all of the Participating Employer's Employees or owners/partners who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

Conditions of Eligibility

A person is eligible for Covered Person coverage from the first day that he or she meets the following requirements:

1) Is a permanent Full-Time Employee, of a Participating Employer who works a minimum of 24 hours per week, if Your Employer offers benefits to its Full-time Employees;
2) Is in a class eligible for coverage; and
3) Completes the Employee Waiting Period as determined by Your Employer (which cannot exceed 90 days and coverage must take effect no later than the 91st day).

Employees become eligible for Covered Person coverage on:

1) The Effective Date in which Your Employer enrolls in this Plan if You were employed on that date; or
2) The first of the month following Your first day of employment (subject to the conditions listed below). You must complete the Employee Waiting Period as determined by Your Employer (which cannot exceed 90 days and coverage must take effect no later than the 91st day).

However, Plan coverage is not automatic. You have to timely enroll in the Plan to be covered as a Covered Person. You must provide proof of employment status, such as a payroll stub and You must complete an enrollment form.

For purposes of eligibility for coverage, Full-Time Employees who are absent because of health Conditions or Injury are treated as if they are Actively at Work and leaves of absence that qualify under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) are treated as periods of active employment to the extent such treatment is required and applicable to the Employer under such laws. Notwithstanding the foregoing, a newly hired or newly eligible Employee must report to work for the Employer in order for any coverage under the Plan to become effective.

Under the Plan, You can elect to cover Your ***eligible Dependents*** for certain coverage (see below). You may make this election only when You are first eligible for this coverage, during the Annual Open Enrollment Period or when You experience a Qualifying Event as described in the Special Enrollment Period section.

ELIGIBLE CLASSES OF DEPENDENTS

A Dependent is eligible for coverage under this Plan as follows, provided that Your Employer offers Dependent coverage.

Participating Employer Election

A Participating Employer that elects to make Dependent coverage available under the Plan may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent Children. If the Participating Employer limits Dependent coverage to Dependent Children, the term "Dependent" as used in this Plan is limited to Dependent Children and **excludes** a legal spouse.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by the Plan.

A Dependent is any one of the following persons:

1) **Legal Spouse.** The term "*Spouse*" shall mean the person recognized as the Covered Person's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator requires a certified copy of a marriage certificate**.**
   Legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
   a) the provisions of the Plan regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended;
   b) the provisions of this Plan regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability**.**
2) **Domestic Partner.** Domestic Partners, of any gender, who have been living in a committed exclusive relationship of mutual caring and support with the Covered Person for a period of 12 months, who intend for the Domestic

Partnership to be permanent are covered under this Plan provided that they meet the following proof requirements. It is required that You provide three documents evidencing the commitment of the relationship. The following documentation for coverage of a Domestic Partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Covered Person's Will; durable power of attorney for healthcare or financial management; Joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party. You may be required to sign an agreement with the Plan that You provide the Plan with notice within 31 days of a break in the Domestic Partnership.

3) **Civil Union Partner.** Pursuant to P.L. 2006, c.103. Civil Union couples are granted all of the same rights as married couple. The Plan requires a copy of the Civil Union Certificate. Civil Union couples do not have to meet Domestic Partner guidelines or provide proof requirements of Domestic Partnership.
4) **Unmarried Child(ren) up to Age 31.** A Dependent of a Covered Person is eligible for coverage between the ages of 26 and 31 provided:
    a. he or she is between the age of 26 and 31;
    b. unmarried;
    c. has no dependent(s) of his or her own;
    d. is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and
    e. is not covered by any other health plan as a Subscriber, insured, enrollee or Covered Person.

    These Dependents will be subject to a discounted single Healthcare Fee rate charged for the Plan in which they are enrolled in and will be covered until their 31st birthday or until the last day of the month for which the required payment has been made, whichever comes first.
5) **Child(ren)** who have not attained age 26 will be eligible for coverage under the Plan**.** Documentation showing eligibility, including but not limited to, birth certificates, records of relevant legal proceedings, separation and divorce decrees must be provided.

    The term "*Children*" or "*Child*" shall include natural Children, adopted Children, Civil Union Partner's Children, Domestic Partner's Children, foster Children or Children placed with a Covered Person in anticipation of adoption or of the Child's becoming a Covered Person's foster Child. Step-Children who reside in the Covered Person's household may also be included as long as a natural parent remains married to the Covered Person and also resides in the same household.

    The phrase "*Child placed with a Covered Person in anticipation of adoption*" refers to a Child whom the Covered Person intends to adopt, whether or not the adoption has become final and who has not attained the age of eighteen (18) as of the date of such placement for adoption.

    The term "*placed*" means the assumption and retention by such Covered Person of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. Coverage of these pre-adoptive Children is in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993. The Child must otherwise be available for adoption and the legal process must have commenced.

    Any Child of a Covered Person who is an alternate recipient under a qualified medical Child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these Children is in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical Child support order procedures are available upon request.
6) **Legal Guardianship.** Should the Covered Person have a court-appointed Legal Guardianship and is within 30 days of the date Legal Guardianship is granted, coverage for the Child becomes effective the date the Legal Guardianship is granted. A Child for whom the Covered Person acquires Legal Guardianship but does not apply to enroll until more than 30 days after the date Legal Guardianship is granted, will not be eligible until the next Annual Open Enrollment Period.
7) **Incapacitated Children.** A Covered Person may have an unmarried Child with Mental Health Conditions or physical incapacity, or Developmental Disability, who is incapable of earning a living. Subject to all of the terms of this section and this Plan, such a Child may stay eligible for Dependent health benefits past this Plan's age limit for eligible Dependents. The Child will stay eligible as long as the Child is and remains unmarried and incapable of earning a living, if:
    a. the Child's Condition started before he or she reached this Plan's age limit;
    b. the Child became covered by this Plan or any other Plan before the Child reached the age limit and stayed continuously covered after reaching such limit; and

c. the Child depends on the Covered Person for most of his or her support and maintenance.
d. However, for the Child to stay eligible, the Covered Person must send the Plan written proof that the Child is incapacitated or Developmentally Disabled and depends on the Covered Person for most of his or her support and maintenance. The Covered Person has 31 days from the date the Child reaches the age limit to do this. The Plan can ask for periodic proof that the Child's Condition continues. However, after two years, the Plan cannot ask for this more than once a year.

ELIGIBILITY LIMITATIONS

The following persons are excluded as Dependents:

1) The divorced former spouse of the Covered Person.
2) Any person who is on active duty in any military service of any country.
3) Other individuals living in the Covered Person's home, but who are not eligible as defined.
4) Dependents of Dependent Children.

FUNDING OF COVERAGE

WHO PAYS THE COST OF COVERAGE

Each Participating Employer shares the cost of the coverage under the Plan with the Covered Person.

Coverage may be contributory. A coverage is contributory when the Covered Person must pay all or part of the cost. If Your Plan is contributory, You must fill out an Enrollment Form. By signing the Enrollment Form, You are agreeing to pay Your part of the cost as agreed to by You and Your Employer. Each Participating Employer sets the level of any Covered Person contributions. Your Employer reserves the right to change the level of Covered Person contributions at any time. Check with Your Employer to obtain details on Your contributions.

ENROLLMENT

HOW TO ENROLL

Each year during the Annual Open Enrollment Period, Your Employer will provide You with information on the Benefit Program for the upcoming year. You will be allowed to change Your level of coverage at that time, subject to Plan guidelines.

An Annual Open Enrollment Period is the one-month period beginning immediately before the Participating Employer's Renewal Date. The Employees of Participating Employers will be notified about the benefit Plan(s) being offered by their Employer. If multiple benefit Plans are offered within this program, all Plans must have the same Annual Open Enrollment Period. The Effective Date of coverage for Employees of a Participating Employer who enroll during open enrollment will be the next Renewal Date following the Annual Open Enrollment Period.

1) Benefit Plan changes are only available at the Participating Employer 's Renewal Date.
2) Benefit Plan changes must be received by the Plan Administrator within 31 days of the Renewal Date.
3) All benefit Plan changes must be submitted in writing.

WHEN COVERAGE BEGINS

If You are a new Employee of a Participating Employer enrolling after the Annual Open Enrollment Period, Your elections become effective as follows:

1) If You are a Full-Time, Actively at Work Employee, working Your regular hours, on the date Your coverage is scheduled to start, and You have met all the conditions of eligibility which apply to You, Your coverage becomes effective on the first day of the month following either**;**
   a) Your date of hire, if Your Employer does not impose a Waiting Period; or
   b) Completion of Your Employer's Waiting Period requirement. You must complete the Employee Waiting Period as determined by Your Employer (which cannot exceed 90 days and coverage must take effect no later than the 91st day).
2) If You are not Actively at Work on the scheduled Effective Date, the Plan will postpone the start of Your coverage until You return to Active Work.
3) If Your status changes from an ineligible Employee of a Participating Employer to one who is eligible to participate in the Plan, coverage is available on the first day of the month that falls on or follows the date of Your change in status, as long as You have satisfied the initial Waiting Period, if any, and completed an enrollment form.

The **Waiting Period** varies by Participating Employer but cannot exceed 90 days. The Waiting Period is defined as the number of days of continuous employment after which an Employee of a Participating Employer becomes eligible for coverage under the Plan. Each Employer may have different Employee Waiting Periods. Check with Your Employer to get details on Your Waiting Period.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he
or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments, if any, within 31 days of the Employee's Eligibility Date. If he or she does this within 31 days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the Effective Date of an Employee's coverage. If the Employee does this more than 31 days after the Employee's Eligibility Date, the Plan will consider the Employee a Late Enrollee. The Employee may request enrollment during the Annual Employee Open Enrollment period. Coverage will take effect on the Participating Employer's Anniversary date following enrollment.

DEPENDENT COVERAGE

Eligibility Requirements for Dependent Coverage

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

When Dependent Coverage Starts

In order for an Employee's Dependent coverage to begin, the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of this Plan, the date an Employee's Dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

1) the first day of the calendar month following the Dependent's Eligibility Date, or
2) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than 30 days after the Dependent's Eligibility Date, the Plan will consider the Dependent a Late Enrollee. An Employee may elect to cover a Dependent who is a Late Enrollee during the Employee Open Enrollment Period. Coverage will take effect on the Participating Employer's Plan Anniversary date following enrollment. Once an Employee has Dependent coverage for Initial Dependents the Employee must notify the Plan of a Newly Acquired Dependent within 30 days after the Newly Acquired Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn Child or newly adopted Child, including a Child placed for adoption, will be covered from the later of:

1) the date the Employee notifies the Plan and agrees to make any additional payments, or
2) the first day of the calendar month following the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Participating Employer who purchased this Plan purchased it to replace a plan the Participating Employer had with some other carrier, a Dependent who is Totally Disabled on the date this Plan takes effect will initially be eligible for limited coverage under this Plan if:

1) the Dependent was validly covered under the Participating Employer's old plan on the date the Participating Employer's old
   plan ended; and
2) this Plan takes effect immediately upon termination of the prior plan.

The coverage under this Plan will be limited to coverage for services or supplies for Conditions other than the disabling Condition. Such limited coverage under this Plan will end one year from the date the person's coverage under this Plan begins. Coverage for services or supplies for the disabling Condition will be provided as stated in an extended health benefits, or like provision, contained in the Participating Employer's old plan. Thereafter coverage will not be limited as described in this provision but will be subject to the terms and conditions of this Plan.

BENEFIT YEAR

Your Benefit Year is the date by which all benefits are tracked. It is the twelve (12) month period beginning on January 1st. This is the date by which all Plan Deductibles, Plan maximums, visit maximums, etc., are tracked. Each Benefit Year Your Plan maximums and Deductibles will be reset.

ENROLLMENT REQUIREMENTS FOR NEWBORN CHILDREN

The Plan will cover an Employee's newborn Child for 60 days from the date of birth without additional Health Care Fees. Coverage may be continued beyond such 60-day period as stated below:

a) If the Employee is already covered for Dependent Child coverage on the date the Child is born, coverage automatically continues beyond the initial 60 days, provided the Health Care Fees and required Employee contributions required for Dependent Child coverage continues to be paid. The Employee must notify the Plan of the birth of the newborn Child as soon as possible in order that the Plan may properly provide benefits under this Plan.

b) If the Employee is not covered for Dependent child coverage on the date the Child is born, the Employee must:
   - give written notice to enroll the newborn Child; and
   - pay the Health Care Fees required for Dependent child coverage within 60 days after the date of birth.

If the notice is not given and the Health Care Fees are not paid within such 60-day period, the newborn Child's coverage will end at the end of such 60-day period. If the notice is given and the Health Care Fees paid after that 60-day period, the Child will be a Late Enrollee.

TIMELY OR LATE ENROLLMENT

1) **Timely Enrollment.** Enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

2) **Late Enrollment.** An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during the Annual Open Enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

WHEN YOU CAN MAKE CHANGES TO YOUR COVERAGE

You may make changes to Your coverage each year during Your Annual Open Enrollment Period. These changes generally remain in effect for 12 consecutive months. However, You may also change Your coverage elections during the year in the situations listed below provided that the Plan is notified within 31 days of the event.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first day of the month following the Qualifying Event. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1) The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
2) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Participating Employer contributions towards the coverage were terminated.
4) Medicare or Medicaid
    a) If You or a Dependent becomes eligible for coverage under Medicare or Medicaid, You may decrease Your medical coverage. Or,
    b) If You or a Dependent loses eligibility for coverage under Medicare or Medicaid, You may increase Your medical coverage.
5) If You have a special enrollment Qualifying Event or any of the following apply, You are allowed to enroll or change Your existing plan option in the Plan after:
    a) a loss of eligibility for group health coverage, health coverage, Children's Health Insurance Plan (CHIP) or Medicaid;
    b) becoming eligible for state premium assistance, Medicaid or CHIP subsidies; or
    c) the acquisition of a new spouse or Dependent by marriage, birth adoption or placement for adoption.
6) The Employee or Dependent requests enrollment in this Plan not later than 31 days of the date of exhaustion of COBRA coverage or the termination of coverage or Participating Employer contributions, described above.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Certain Special Enrollment rights also exist for Employees or Dependents who lose coverage under the Children's Health Insurance Program (CHIP) under Medicaid and State Children's Programs.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The purpose of CHIP is to provide funding for Children's Health Insurance under Medicaid and State Children's Programs and to allow a Group Health Plan to permit special enrollment for eligible but not enrolled Employees or Dependent Children who either:

1) lose coverage under a Medicaid or a State Children's Health Insurance Plan (SCHIP) under titles XIX and XXI of the Social Security Act, respectively, or
2) become eligible for Group Health Plan premium assistance under Medicaid or SCHIP (Special Enrollment Right).

The Covered Person or Dependent must request coverage no later than sixty (60) days after the date eligibility is lost or the date the Covered Person and/or Dependent is determined to be eligible for State contribution assistance.

Dependent Beneficiaries. Generally, a Covered Person must enroll Dependents during the Annual Open Enrollment Period. Special enrollment is permitted if a Covered Person enrolls Dependents due to a Qualifying Event. The coverage for the Dependent will become effective on the following dates corresponding to the Qualifying Event:

1) In the case of marriage, not later than the first day of the first calendar month beginning after the completed request for enrollment is received;

2) In the case of a Dependent's birth, as of the date of birth; or
3) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

To enroll under any of the above Special Enrollment circumstances, You must notify Your Employer and fill out the change in coverage section of the Enrollment Form. All information must be completed, the form signed, and all required proof attached to the Enrollment Form. Or, You can contact the Plan Administrator. You must enroll within 31 days of Your loss of other coverage.

WHEN COVERAGE ENDS

When Employer's Coverage Ends

Participating Employer's coverage can be terminated on the earliest of the following dates:

1) If required Health Care Fees for coverage for Covered Persons is not received, or moneys are not available for debit from a bank account by the 5th of the month, all coverage for a Participating Employer's Covered Persons will be terminated retroactive back to the 1st of the month for which payment was due. If payment is received within 30 days of the due date, reinstatement will be permissible up to two (2) times.
2) Upon renewal, if it is determined that the Participating Employer no longer meets the Group Eligibility requirements.

When Your Coverage Ends

Your Covered Person coverage ends on the earliest of the following dates:

1) The date the Plan is terminated by the Employer;
2) The date the Plan is terminated by the Trust for Employer non-compliance or non-payment of required Health Care Fees;
3) The end of the month in which You terminate employment with Your Employer for any reason, including disability, death, retirement, lay-off, leave of absence or termination of employment;
4) The date You no longer meet eligibility requirements;
5) The day the Covered Person enters the military, Navy or Air Force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any Calendar Year (Refer to Employees on Military Leave).
6) The end of the month during which any Plan ends, or is discontinued for a class of Employees to which You belong;
7) The last day of the period for which Your required contribution has been paid if the charge for the next period is not paid when due; or
8) The end of the month during which You or a covered Dependent become entitled to Medicare, unless You are Actively at Work.

When Dependent Coverage Ends

A covered Dependent's coverage ends on the earliest of the following dates:

1) date the Plan is terminated;
2) last day of the calendar month during which Your Dependent no longer meets eligibility requirements: reaching the age of 26 or 31;
3) date Your coverage ends;
4) last day of the calendar month during which You stop being a Covered Person of a class of Employees eligible for coverage;
5) last day of the calendar month during which an applicable Plan of benefits ends;
6) last day of the period for which required payments have been made for You by Your Employer;
7) the last day of the period for which Your required contribution has been paid if the charge for the next period is not paid when due; or
8) last day of the calendar month during which Your Dependent reaches age 65, unless You are Actively at Work.

Your Dependent may be eligible to continue health care coverage after termination through COBRA or New Jersey Continuation (see Continuing Coverage Section for more information).

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff

You may remain eligible for a limited time if active, Full-Time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

1) For disability leave only: the date the Employer ends the continuance.
2) For leave of absence or layoff only: the date the Employer ends the continuance.

CONTINUATION OF COVERAGE

In addition to COBRA and Continuation Coverage (discussed later in this Plan in the section entitled *Continuing Coverage*), coverage may be continued in the following circumstances:

Continuation During Family and Medical Leave (FMLA)

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 and the regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under the Plan on the same conditions as coverage would have been provided if the Covered Person had been continuously employed during the FMLA leave period.

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

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act under the following circumstances (these rights apply only to Covered Persons and their Dependents covered under the Plan before leaving for military service):

1) The maximum period of coverage for a Covered Person and the Covered Person's Dependent(s) under such an election shall be the lesser of:
   a) The twenty-four (24) month period beginning on the date on which the Covered Person's absence begins; or
   b) The day after the date on which the Covered Person was required to apply for or return to a position or employment and fails to do so.
2) A previously Covered Person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3) A Plan Exclusion or Waiting Period, if any, may not be imposed in connection with the reinstatement of coverage upon the Covered Person's re-employment, if one would not have been imposed had coverage not been terminated because of the Covered Person's military service. However, a Plan Exclusion or Waiting Period, if any, may be applied for coverage of any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed (military) service.

CERTIFICATES OF CREDITABLE COVERAGE

The Plan will provide You with a Certificate of Creditable Coverage, only upon request, detailing the beginning and ending dates of Your Plan coverage when You become eligible for COBRA or New Jersey Continuation and when Your coverage otherwise ends. You can request a Certificate of Coverage at any time for up to two (2) years after Your coverage under this Plan ends by contacting the Plan Administrator.

OPEN ENROLLMENT

WHEN YOU CAN ENROLL

During Your Employer's Annual Open Enrollment Period (refer to section "Plan Administration Information" for more information), covered Employees and their covered Dependents will be able to change their current benefit elections based on which benefits and coverage levels are right for them. In addition, Employees and their Dependents who are Late Enrollees will also be able to enroll in the Plan during this period.

Benefit choices made during the open enrollment period will become effective based on Your Employer's Renewal Date (either January 1st, April 1st, July 1st, October 1st) and remain in effect until the next January 1st, April 1st, July 1st, October 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption, or leave of absence) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one plan to another plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective based on Your Employer's Renewal Date (either January 1st, April 1st, July 1st, October 1st)

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present or comparable coverage if a Plan is eliminated.

Covered Employees will receive detailed information regarding open enrollment from their Employer.

PLAN PROVISIONS

REFER TO ATTACHED SCHEDULE OF BENEFITS FOR THE PLAN YOU ARE ENROLLED IN FOR DETAILED PLAN DESIGN COMPONENTS

WHAT ARE THE BENEFITS?

All benefits described in this Plan Document and Summary Plan Description and **attached Schedule of Benefits** are subject to the exclusions and limitations described more fully herein including, but not limited to, the medical Claims Administrator's Determination that care is: (i) not Medically Necessary and Appropriate; (ii) not based on the Plan's Allowable Charges; and (iii) Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

It is the Covered Person's choice as to which Provider to use. Some services are not covered when provided by an Out-of-Network Provider. Review the **attached Schedule of Benefits** and remainder of this document carefully. If You are covered under a Network Only Benefit Plan, You have no Out-of-Network benefit. You may only receive coverage for services provided by In-Network Providers. In the event of an Emergency, please proceed to the nearest Emergency Facility for treatment. Out-of-Network Emergency services will be allowed at the same level of benefits as In-Network services.

If You or a covered Dependent need covered services recommended by Your Physician that are not available within the Network, Medical Management Review/ medical Claims Administrator may, at its Discretion, determine the services are Medically Necessary and Appropriate, and approve the use of an Out-of-Network Provider. When approved through Medical Management Review Services and/or the medical Claims Administrator, benefits for use of these Providers will be payable at the same level as those of Network Providers, had those services been available. Reimbursement will be considered based on billed charges.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim review. While every claim may not be subject to a bill review or audit, the Plan Administrator has discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary Charges and/or Medically Necessary and Appropriate, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

BALANCE BILLING

In the event that a claim submitted by a Network or an Out of Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Out- of-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

BENEFIT PLANS - HOW THE PLAN WORKS

Please read Your Schedule of Benefits carefully and make sure You are reviewing the Benefit Plan that You and Your Dependents are enrolled in. If You have any questions regarding which Benefit Plan You are enrolled in, please contact the Plan.

Refer to Your Schedule of Benefits for Your specific Benefit Plan provisions including Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out-of- Pocket Amounts.

Copayments or Copay
A Copayment is a small amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments accrue toward the 100% Maximum Out-of-Pocket payment. Refer to the Schedule of Benefits for Copayment amounts.

Deductibles
A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. It must be paid before any money is paid by this Plan for any covered services (with a few exceptions). The Deductible is based on the benefit year and each January 1st, a new Deductible amount is required. The Deductible is in addition to any Hospital admission Deductible or Hospital outpatient visit Deductible (if and when applicable) as shown in the Schedule of Benefits.

Aggregating Deductible. (HSA Compatible Plans have this Deductible)
If Your Plan has an Aggregating Deductible, You must satisfy the Family "Deductible" or the Family “Maximum Out-of-pocket" in full if enrolled in coverage other than individual or Employee only coverage. The Plan doesn’t begin paying for the health care expenses of anyone in the family until the entire family Deductible has been met. If You have individual coverage, the Plan doesn’t begin paying for health care expenses until the individual Deductible has been met. Refer to the Schedule of Benefits for Individual and Family amounts.

Embedded Deductible
If Your Plan has an Embedded Deductible, You can satisfy the Family "Deductible" or the Family “Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family member and then any combination of family members may satisfy the remaining amount. No more than the individual amount will be credited to the Family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year. Refer to the Schedule of Benefits for Individual and Family amounts.

Maximum Out-of-Pocket
The annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Plan Benefit Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out-of-Pocket. Once the Maximum Out-of-Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Plan Benefit Year.

Charges for the following do not apply to the 100% benefit limit and are never paid at 100%:

- ✓ Cost containment penalties (failure to obtain Medical Precertification of services).
- ✓ Any charges considered as non-covered (e.g., any amounts above the Plan’s Allowable Charges, charges for non-covered services)

Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while covered by this Plan can be used to meet the Deductible. What the Plan pays is based on all the terms of this Plan.

SUMMARY OF COVERED SERVICES AND SUPPLIES

The following Covered Charges are reimbursed based on the Plan's Allowable Charges for all Plans unless specifically indicated otherwise and may be subject to the Determination of Medical Necessity and Appropriateness, Plan Deductibles, Coinsurance, Copayment, or day/visit limitations. Please refer to the Schedule of Benefits for Your Plan for more detailed benefit information.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

ABORTION

Charges incurred for an elective abortion and therapeutic abortion when Pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical Condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

ACUPUNCTURE

Acupuncture services and supplies are covered when: (a) the Acupuncture is performed for anesthetic purposes by a Practitioner; and
(b) the services are Precertified as being Medically Necessary and Appropriate.

ALLERGY TESTS/TREATMENT

Charges incurred for allergy tests and allergy treatments are considered covered services under this Plan.

AMBULANCE SERVICES

The Plan covers ground and/or air Ambulance services when Medically Necessary and Appropriate. Services require Medical Precertification in advance by the Plan (except in a medical Emergency). Medical Precertification for a non-Emergency Ambulance is required.

Medically Necessary and Appropriate charges for transporting You to:

1) A local Hospital if needed care and treatment can be provided by a local Hospital,
2) The nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment (it must be in connection with an Inpatient confinement), or
3) Transporting a Covered Person to another Inpatient Healthcare Facility.

Air or Water Ambulance

Covered expenses include charges for transportation to a Hospital by air or water Ambulance when:

1) Ground Ambulance transportation is not available; and
2) Your Condition is unstable, and requires medical supervision and rapid transport; and
3) In a medical Emergency, transportation from one Hospital to another Hospital; when the first Hospital does not have the required services or facilities to treat Your Condition and You need to be transported to another Hospital; and the two conditions above are met.

Ground Ambulance

Covered expenses include charges for transportation:

1) To the first Hospital where treatment is given in a medical Emergency.
2) From one Hospital to another Hospital in a medical Emergency when the first Hospital does not have the required services or facilities to treat Your Condition.
3) From Hospital to home or to another Facility when other means of transportation would be considered unsafe due to Your medical Condition.
4) From home to Hospital for covered Inpatient or outpatient treatment when other means of transportation would be considered unsafe due to Your medical Condition.
5) When during a covered Inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to safely and adequately transport You to or from Inpatient or outpatient Medically Necessary and Appropriate treatment.

Note: *The Plan does not pay for chartered air flights, or any other travel or communication expenses of patients, Physicians, Nurses or family members inside or outside the United States*

AMBULATORY SURGICAL CENTER CHARGES

The Plan covers Ambulatory Surgical Center charges in connection with covered Surgery. Services require Medical Precertification in advance by the Plan when required.

ANESTHETICS AND OTHER SERVICES AND SUPPLIES

The following anesthetic and other services and supplies are covered:

1) Anesthetics and their administration, hemodialysis, casts, splints, Prosthetic Appliances, surgical dressings and the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches.
2) The Plan covers Medically Necessary and Appropriate replacements or repairs for braces, orthopedic footwear and crutches.

AUTISM AND OTHER DEVELOPMENTAL DISABILITIES

Diagnosis and Treatment

The Plan provides coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities. If a Covered Person's primary diagnosis is autism or another Developmental Disability, the Plan provides coverage for the following therapies as prescribed through a treatment plan. These are facilitative services in that they are provided to develop rather than restore a function. The Therapy Services are subject to the benefit limits set forth below:

1) occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
2) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
3) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Plan Year for the treatment of Conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Plan Year for the treatment of Conditions other than autism.

These Therapy Services are covered whether or not the therapies are restorative. The Therapy Services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision.

If a Covered Person's primary diagnosis is autism, in addition to coverage for the Therapy Services as described above, the Plan also covers Medically Necessary and Appropriate behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating Physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. The Plan may request additional information if necessary to determine the coverage under the Plan. The Plan may require the submission of an updated treatment plan once every six months unless the Plan and the treating Physician agree to more frequent updates.

If a Covered Person:

1) is eligible for early intervention services through the New Jersey Early Intervention System; and
2) has been diagnosed with autism or other Developmental Disability; and
3) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services.

Then the portion of the family cost share attributable to such services is a Covered Charge under this Plan. The Deductible, Coinsurance or Copayment, as applicable to a non-Specialist Physician visit for treatment of an Illness or Injury, will apply to the family cost share.

The Therapy Services a Covered Person receives through New Jersey Early Intervention do not reduce the Therapy Services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a Birthing Center provided the Physician in charge is acting within the scope of his license and the Birthing Center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a covered expense if the state in which such service is performed has legally recognized midwife delivery. Coverage is provided for prenatal care, delivery, and postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

BLOOD

Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, the Plan covers blood, blood products, blood transfusions and the cost of testing and processing blood. But the Plan does not pay for blood which has been donated or replaced on behalf of the Covered Person.

CANCER CLINICAL TRIAL

The Plan covers Practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a Condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. The Plan will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

The Plan does not cover the cost of Investigational Drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Plan for treatments that are not Experimental or Investigational.

CARDIAC REHABILITATION

Cardiac rehabilitation as deemed Medically Necessary and Appropriate provided services are rendered

1) Under the supervision of a Physician;
2) In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
3) Initiated within 12 weeks after other treatment for the medical Condition ends; and
4) In a Medical Care Facility as defined by this Plan.

CHARGES FOR THE TREATMENT OF HEMOPHILIA

The Plan covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

The Plan will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are Medically Necessary and Appropriate immediately or sooner than the normal return time for the Plan's network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by the Plan's network clinical laboratory. The Plan will pay the Hospital's clinical laboratory for the laboratory services at the same rate the Plan's would pay a Network clinical laboratory for comparable services.

CHIROPRACTIC SERVICES/SPINAL MANIPULATION

Chiropractic Services/Spinal Manipulation by a licensed M.D., D.O. or D.C. for Covered Persons age 18 and older only.

CLINICAL TRIAL

The coverage described in this provision applies to Covered Persons who are eligible to participate in an approved Clinical Trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life-threatening Condition. The Plan provides coverage for the Clinical Trial if the Covered Person's Practitioner is participating in the Clinical Trial and has concluded that the Covered Person's participation would be appropriate; or the Covered Person provides medical and scientific information establishing that his or her participation in the Clinical Trial would be appropriate.

The Plan provides coverage of routine patient costs for items and services furnished in connection with participation in the Clinical Trial. The level of benefit for Medically Necessary and Appropriate routine care received will correspond to the network participation status of the Clinical Trial's Provider(s) and Facility. If out of network benefits for routine care are not available under the Covered Person's plan, benefits for routine care within a Clinical Trial from out of Network Providers are also not available.

The Plan will not deny a qualified Covered Person participation in an approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or Condition. The Plan will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the Clinical Trial. The Plan will not discriminate against the Covered Person on the basis of the Covered Person's participation in the Clinical Trial.

COSMETIC SURGERY

Cosmetic Surgery shall only be a covered expense in the event:

1) A Covered Person receives an Injury because of an accident and as a result requires Surgery. Cosmetic Surgery and treatment must be for the purpose of restoring the Covered Person to his normal function immediately prior to the accident; or,
2) It is required to correct a congenital anomaly, for example, a birth defect for a Child.

Mastectomy

The Plan covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. The Plan also covers treatment of the physical complications of mastectomy, including lymphedemas.

Correction of abnormal congenital Conditions and reconstructive mammoplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

1) reconstruction of the breast on which a mastectomy has been performed,
2) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas and post mastectomy bras, in a manner determined in consultation with Your Physician.

COVERED NEWBORN CHILD

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.

DENTAL PROSTHETIC APPLIANCES

The Plan covers dental Prosthetic Appliances or devices only when resulting from accidental Injury to teeth within six months of an accidental Injury. Orthotic Appliances must correct a defect of body form or function. Only the basic device is covered, and any Medically Necessary and Appropriate special features require Medical Precertification.

DENTAL SERVICES

Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

1) The diagnosis and treatment of oral tumors and cysts; and
2) The surgical removal of bony impacted teeth; and
3) Surgical and non-Surgical treatment of Temporomandibular joint dysfunction syndrome (TMJ) in a Covered Person. But, this Plan does not cover charges for orthodontia, crowns or bridgework. "Surgery", if needed, includes the preoperative and post- operative care connected with it.

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.

For a Covered Person who is severely disabled or who is a Child Dependent under age six, coverage shall also be provided for the following:

1) General anesthesia and Hospital Admission for dental services; or
2) Dental services rendered by a Dentist, regardless of where the dental services are rendered, for medical Conditions that:
    a) Are covered by this Plan; and
    b) require a Hospital Admission for general anesthesia

This coverage shall be subject to the same Medical Management Review and rules imposed upon all Inpatient stays.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures, crowns and/or routine dental care with the exception of dental bridge work when the services are required for the management of a congenital anomaly.

DIABETIC SERVICES, SUPPLIES AND TRAINING

Charges for the treatment of diabetes must be recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse in order to be considered as Covered Charges under this Plan. The following equipment and supplies are Covered Charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

1) blood glucose monitors;
2) blood glucose monitors for the legally blind;
3) cartridges for the legally blind;
4) injection aids;
5) insulin;
6) insulin infusion devices;
7) insulin pumps and necessary accessories;
8) lancets;
9) needles and syringes;
10) oral agents for controlling blood sugar levels;
11) test strips for glucose monitors; and
12) visual reading and urine testing strips.

The following services and training are eligible charges:

1) routine diabetes foot care;
2) self-management education which is provided by a health care professional recognized as a Certified Diabetes Educator, a Registered Dietician or a state licensed Pharmacist; and
3) nutritional counseling.

Note: Benefits for self-management and nutritional counseling and education will be provided for any of the following three (3) reasons:

1) when diabetes is diagnosed;
2) when a change in self-management occurs through a significant change in a Covered Person's Conditions or symptoms; or
3) re-education is required.

Some supplies may be available at In-Network Pharmacies through the Prescription Plan (if You have Prescription coverage) or may be available through an In-Network DME Provider through the DME benefit.

DIALYSIS CENTER CHARGES

The Plan covers charges made by a dialysis center for covered dialysis services. These services and supplies must be Precertified by the Plan.

DIGITAL TOMOSYNTHESIS CHARGES

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 tomosysthesis as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.
2) 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.

DONATED HUMAN BREAST MILK

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.

DURABLE MEDICAL EQUIPMENT (DME)

The Plan includes the expense of renting or buying DME and accessories You need to obtain the item from an In-Network DME supplier. Your Plan will cover either buying or renting the item, depending on which is more cost efficient. If You purchase DME, that purchase is only eligible for coverage if You need it for long-term use.

Coverage includes:

1) One item of DME for the same or similar purpose.
2) Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
3) A new DME item You need because Your physical Condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

EMERGENCY AND URGENT CARE SERVICES

Do not delay getting medical care in the event of an Emergency. If a Hospital admission and/or Surgery is required due to a life- threatening Illness or Injury, get the immediate care You need. Then, You or Your Physician must call the phone number listed on the back of Your ID card within 48 hours, or as soon as possible after the admission occurs. In addition, You or Your doctor must request a continued stay review for any Emergency admission.

Charges for services and supplies for the treatment of an emergency medical Condition or an urgent Condition.

As always, You can get emergency care from network Providers. However, You can also get emergency care from Out-of-Network Providers.

Your coverage for emergency services and urgent care from Out-of-Network Providers ends when Aetna and the attending Physician determine that You are medically able to travel or to be transported to a network Provider if You need more care.

As it applies to In-Network coverage, You are covered for follow-up care only when Your Physician or PCP provides or coordinates it. If You use an Out-of-Network Provider to receive follow up care, You are subject to a higher out-of-pocket expense.

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.

IN CASE OF A MEDICAL EMERGENCY

When You experience an emergency medical Condition, You should go to the nearest emergency room. You can also dial 911 or Your local emergency response service for medical and ambulance assistance. If possible, call Your Physician or PCP but only if a delay will not harm Your health.

Non-emergency Condition

If You go to an emergency room for what is not an emergency medical Condition, the Plan may not cover Your expenses. See the schedule of benefits and the *exclusion- Emergency services and urgent care and Medical Precertification benefit reduction* sections for specific Plan details.

IN CASE OF AN URGENT CONDITION

Urgent Condition

If You need care for an urgent Condition, You should first seek care through Your Physician or PCP. If Your Physician or PCP is not reasonably available to provide services, You may access urgent care from an urgent care Facility.

Non-urgent care
If You go to an urgent care Facility for what is not an urgent Condition, the Plan may not cover Your expenses.

Care Not Available Within the Network
The Plan has a special feature for those rare instances in which You need care that is not available within the Network. This feature permits You to get specialized care for certain procedures from Out-of-Network Providers and receive the network level of benefits. Any Physician charges provided during an Inpatient/outpatient stay must be Medically Necessary and Appropriate as determined by the Plan.

Elective care will be reimbursed at the Out-of-Network level, if You have Out-of-Network benefits. You should always try to find an In- Network Provider for these services to lessen Your out of pocket expenses.

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 Necessity and Appropriateness is made by the Covered Person's physician for the first 180 days of network treatment.

FERTILITY SERVICES
Fertility Services, Subject to Medical Precertification, are covered for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in this Plan. The Plan covers charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Plan.

Exclusions
Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:
See also the separate Exclusion addressing sterilization reversal.

a) Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
b) All charges associated with:
   - Surrogacy for You or the Surrogate. A Surrogate is a female carrying her own genetically related Child where the Child is conceived with the intention of turning the Child over to be raised by others, including the biological father.
   - Cryopreservation (freezing) of eggs, embryos or sperm.
   - Storage of eggs, embryos, or sperm.
   - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
   - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
   - The use of a Gestational Carrier for the female acting as the gestational carrier. A Gestational Carrier is a female carrying an embryo to which she is not genetically related.
   - Obtaining sperm from a person not covered under this Plan.
c) Home ovulation prediction kits or home pregnancy tests.
d) The purchase of donor embryos, donor oocytes, or donor sperm.
e) Reversal of voluntary sterilizations, including follow-up care.
f) In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
g) Prescription Drugs not eligible under the Prescription Drugs section of the Plan

HEARING AIDS
The Plan covers charges for Medically Necessary and Appropriate services incurred in the purchase of a hearing aid for a Covered Person age 15 or Younger. Benefits provided are a for each hearing-impaired ear. Coverage for all other Medically Necessary and Appropriate services incurred in the purchase of a hearing aid is unlimited. Such Medically Necessary and Appropriate services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed Physician

or audiologist.

The Deductible, Coinsurance or Copayment applicable to Durable Medical Equipment will apply to the purchase of a hearing aid. The Deductible, Coinsurance or Copayment as applicable to a non-Specialist Physician visit for treatment of an Illness or Injury will apply to the Medically Necessary and Appropriate services incurred in the purchase of a hearing aid.

HOME HEALTH CARE CHARGES

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.

HOSPICE CARE

Charges inpatient and outpatient Hospice care when given as part of a Hospice Care Plan. The types of Hospice Care Services that are eligible for coverage include:

1) Room and board
2) Services and supplies furnished to You on an inpatient or outpatient basis
3) Services by a Hospice Agency or Hospice care provided in a Hospital
4) Bereavement counseling
5) Respite care

Hospice Care Services provided by the Providers below may be covered, even if the Providers are not an employee of the Hospice Agency responsible for Your care:

1) A Physician for consultation or case management
2) A physical or occupational therapist
3) A home health care agency for:
   - Physical and occupational therapy
   - Medical supplies
   - Outpatient prescription drugs
   - Psychological counseling
   - Dietary counseling

HOSPITAL SERVICES

Charges for inpatient and outpatient Hospital care.

The types of Hospital care services that are eligible for coverage include:

1) Room and board charge up to the Hospital's semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of Your medical Condition.
2) Services of Physicians employed by the Hospital.
3) Operating and recovery rooms.
4) Intensive or special care units of a Hospital.
5) Administration of blood and blood derivatives, but not the expense of the blood or blood product.
6) Radiation therapy.
7) Cognitive rehabilitation.
8) Speech therapy, physical therapy and occupational therapy.
9) Oxygen and oxygen therapy.
10) Radiological services, laboratory testing and Diagnostic Services.
11) Medications.
12) Intravenous (IV) preparations.
13) Discharge planning.
14) Services and supplies provided by the outpatient department of a Hospital.

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.

INHERITED METABOLIC DISEASE

The Plan covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products as determined to be Medically Necessary and Appropriate by the Covered Person's Physician.

LABORATORY TESTS AND X-RAYS

X-rays and laboratory tests that are Medically Necessary and Appropriate to treat an Illness or Injury are covered by the Plan. However, the Plan does not pay for X-rays and tests performed as part of a routine physical checkup, unless specifically listed in the PREVENTIVE CARE SERVICES FOR ADULTS AND CHILDREN section. The Plan covers costs for services including Magnetic Resonance Imaging (MRI) and CAT scans, but not dental x-rays unless related to covered services.

Note: Medical Precertification may be required on imaging. You can access the full list of services that require Medical Precertification on the Plan's website at www.membershealthplannj.com.

MAMMOGRAMS

The Plan covers charges for:

1) Baseline mammography between 35 and 39 years of age
2) Annual Mammography and cytologic screening (annual exams age 40 and over)
3) More frequent Mammography if recommended by Your Physician
4) Includes two-dimensional and three-dimensional mammography
5) A mammogram at the ages and intervals the Covered Person's Practitioner deems to be Medically Necessary and Appropriate with respect to a Covered Person who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the Conditions listed below are satisfied after a Baseline mammogram, the Plan will cover charges for:

1) an ultrasound evaluation;
2) a magnetic resonance imaging scan;
3) a three-dimensional mammography; and
4) other additional testing of the breasts.

The above additional charges will be covered if one of following Conditions are satisfied.

1) The mammogram demonstrates extremely dense breast tissue;
2) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
3) If the Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

See also the following benefit for Digital Tomosynthesis.

MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

The Plan covers the following Mental Health Conditions and Substance Use Disorders services. To receive the In-Network level of benefits, services must be provided by an In-Network Physician at the Provider's office or at an In-Network Facility. Bereavement Counseling (including Hospice bereavement) is covered as an outpatient office visit.

Mental Health Condition Treatment

Covered Charges include the treatment of Mental Health Conditions provided by a Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician or Behavioral Health Provider as follows:

- Inpatient room and board at the semi-private room rate, and other services and supplies related to Your Condition that are provided during Your stay in a Hospital, Psychiatric Hospital, or Residential Treatment Facility. Court ordered admissions are not covered.

- Outpatient treatment received while not confined as an Inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility, including:
  - Office visits to a Physician or Behavioral Health Provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group and family therapies for the treatment of Mental Health Conditions
  - Other outpatient Mental Health Conditions treatment such as:
    - Partial Hospitalization treatment provided in a Facility or program for Mental Health Conditions treatment provided under the direction of a Physician
    - Intensive outpatient program provided in a Facility or program for Mental Health Conditions treatment

provided under the direction of a Physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
        - You are homebound
        - Your Physician orders them
        - The services take the place of a stay in a Hospital or a Residential Treatment Facility, or you are unable to receive the same services outside Your home
        - The skilled behavioral health care is appropriate for the active treatment of a Condition, illness or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23-hour observation
    - Peer counseling support by a peer support specialist
        - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided, or a private certifying organization recognized by us. Peer support must be supervised by a Behavioral Health Provider.

Substance Use Disorders treatment

Covered Charges include the treatment of Substance Use Disorders provided by a Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician or Behavioral Health Provider as follows:

- Inpatient room and board, at the semi-private room rate and other services and supplies that are provided during Your stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Treatment of Substance Use Disorders in a general medical Hospital is only covered if you are admitted to the Hospital's separate Substance Use Disorders or unit, unless you are admitted for the treatment of medical complications of Substance Use Disorders. Court ordered chemical dependency admissions are not covered.

  As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility, including:
    - Office visits to a Physician or Behavioral Health Provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
    - Individual, group and family therapies for the treatment of Substance Use Disorders
    - Other outpatient Substance Use Disorders treatment such as:
        - Outpatient detoxification
        - Partial Hospitalization treatment provided in a Facility or program for treatment of Substance Use Disorders provided under the direction of a Physician
        - Intensive outpatient program provided in a Facility or program for treatment of Substance Use Disorders provided under the direction of a Physician
        - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other Substance Use Disorders, including administration of medications
        - Treatment of withdrawal symptoms
        - 23-hour observation
        - Peer counseling support by a peer support specialist
            - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided, or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

The Plan provides benefits for the treatment of Substance Use Disorders at Network Facilities subject to the following:

- the prospective Determination of Medically Necessary and Appropriateness is made by the Covered Person's Practitioner for the first 180 days of treatment during each Plan Year and for the balance of the Plan Year the Determination of Medically Necessary and Appropriateness is made by the Plan;
- Medical Precertification is not required for the first 180 days of Inpatient and/or outpatient treatment during each Plan Year but may be required for Inpatient treatment for the balance of the Plan Year;
- Concurrent and retrospective review are not required for the first 28 days of Inpatient treatment during each Plan Year, but concurrent and retrospective review may be required for the balance of the Plan Year;

- Retrospective review is not required for the first 28 days of intensive outpatient and Partial Hospitalization services during each Plan Year, but retrospective review may be required for the balance of the Plan Year;
- Retrospective review is not required for the first 180 days of outpatient treatment including outpatient Prescription Drugs, during each Plan Year but retrospective review may be required for the balance of the Plan Year; and
- If no In-Network Facility is available to provide Inpatient services, the Plan shall approve an In-Network exception and provide benefits for Inpatient services at an Out-of-Network Facility.

The first 180 days per Plan Year assumes 180 Inpatient days whether consecutive or intermittent. Extended outpatient services such as Partial Hospitalization and intensive outpatient are counted as Inpatient days. Any unused Inpatient days may be exchanged for two outpatient visits.

Inpatient or day treatment may be furnished by any licensed, certified or State approved Facility, including but not limited to:

- a Hospital
- a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
- a licensed, certified or state approved Residential Treatment Facility under a program which meets the minimum standards of care of The Joint Commission;
- a Mental Health Conditions Facility;
- a Substance Use Disorders Facility; or
- a combination Mental Health Conditions Facility and Substance Use Disorders Facility.

NUTRITIONAL COUNSELING

Subject to Precertification, the Plan covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

ORALLY ADMINISTERED ANTI-CANCER PRESCRIPTION DRUGS

As used in this provision, Orally Administered Anti-Cancer Prescription Drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer Prescription Drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Plan.

The Plan covers Orally Administered Anti-Cancer Prescription Drugs that are Medically Necessary and Appropriate as Network Services and supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs. The Plan covers Orally Administered Anti-Cancer Prescription Drugs that are Medically Necessary and Appropriate as Out-of-Network Services and Supplies if the Covered Person is receiving care and treatment from a Out-of-Network Practitioner who writes the prescription for such Prescription Drugs.

Anti-cancer prescription Drugs are covered subject to the terms of the Prescription Drugs provision of the Plan as stated above. The Covered Person must pay the Deductible and/or Coinsurance required for Prescription Drugs. Using the receipt from the Pharmacy, the Covered Person may then submit a claim for the anti-cancer Prescription Drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Plan. Upon receipt of such a claim the Plan will compare the coverage for the orally-administered anti-cancer prescription Drugs as covered under the Prescription Drugs provision to the coverage the Plan would have provided if the Covered Person had received intravenously administered or injected anti-cancer medications (from the Network or Out-of-Network Practitioner, as applicable) to determine which is more favorable to the Covered Person in terms of Copayment, Deductible and/or Coinsurance. If the Plan provides different Copayment, Deductible or Coinsurance for different places of service, the comparison shall be to the location for which the Copayment Deductible and Coinsurance is more favorable to the Covered Person. If a Covered Person paid a Deductible and/or Coinsurance under the Prescription Drug provision that exceeds the Copayment, Deductible and/or Coinsurance that would have applied for intravenously administered or injected anti-cancer medications the Covered Person will be reimbursed for the difference.

ORTHOTIC APPLIANCE (see "Durable Medical Equipment").

OSTOMY SUPPLIES

The following equipment and supplies are Covered Charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

- Pouch	- Adhesives/Removers	- Dressings	- Appliance Cleaners
- Ostomy Belts	- Skin Barriers/Wafers	- Irrigators	- Closures

PHYSICIAN SERVICES

Covered expenses shall include:

1) Charges made by a Physician during a visit to treat Illness or Injury. The visit may be at the Physician's office, in Your home, or in a Hospital or other Facility during Your stay or in an outpatient Facility.
2) Surgical treatment.
3) Surgical assistance provided by a Physician if it is determined that the Condition of the Covered Person or the type of surgical procedure requires such assistance.
4) Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
5) Consultations requested by the attending Physician during a Hospital confinement. Consultations do not include staff consultations that are required by a Hospital's rules and regulations.
6) Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7) Radiologist or pathologist services for diagnosis or treatment, including Radiation Therapy and Chemotherapy.
8) Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

The Plan covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.

PRACTITIONER'S CHARGES FOR SURGERY

The Plan covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

The Plan does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

PREGNANCY BENEFITS

Group Health Plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a Provider obtain Medical Precertification from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRESCRIPTIONS

Prescription Drugs when provided as part of a covered Inpatient admission are covered.

See Prescription Drug Section of this document for more information on Your Prescription Drug Card Program.

PREVENTIVE CARE SERVICES FOR ADULTS AND CHILDREN

This section describes the covered services and supplies available under Your plan when You are well. You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for Children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this Plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

Diagnostic testing will not be covered under the preventive care benefit. For those tests, You will pay the cost sharing specific to Covered Charges for diagnostic testing.

Gender- specific preventive care benefits include Covered Charges described below regardless of the sex You were assigned at birth, Your gender identity, or Your recorded gender.

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact Your Physician or contact the Plan at www.membershealthplannj.com or at the phone number listed on the back of Your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Covered services include office visits to Your Physician, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for Children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial Hospital checkup.

Preventive care immunizations

Covered services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to Your employment or travel.

Well woman preventive visits

Covered services include Your routine:

- Well woman preventive exam office visit to Your Physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a Physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

Covered services include screening and counseling by Your health professional for some Conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services You get in an individual or group setting. Here is more detail about those benefits.

1) Obesity and/or healthy diet counseling
   Covered services include the following screening and counseling services to aid in weight reduction due to obesity:
   a) Preventive counseling visits and/or risk factor reduction intervention
   b) Nutritional counseling
   c) Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

2) Misuse of alcohol and/or drugs
   Covered services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
   a) Preventive counseling visits
   b) Risk factor reduction intervention

c) A structured assessment

3) Use of tobacco products
Covered services include the following screening and counseling services to help You to stop the use of tobacco products:
   a) Preventive counseling visits
   b) Treatment visits
   c) Class visits
   d) Tobacco cessation prescription and over-the-counter drugs
      i. Covered Charges include FDA- approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

   Tobacco product means a substance containing tobacco or nicotine such as:
   a) Cigarettes
   b) Cigars
   c) Smoking tobacco
   d) Snuff
   e) Smokeless tobacco
   f) Candy-like products that contain tobacco

4) Sexually transmitted infection counseling
Covered services include the counseling services to help You prevent or reduce sexually transmitted infections.

5) Genetic risk counseling for breast and ovarian cancer
Covered services include counseling and evaluation services to help You assess whether or not You are at increased risk for breast and ovarian cancer.

Routine cancer screenings
Covered services include the following routine cancer screenings:
1) Mammograms
2) Prostate specific antigen (PSA) tests
3) Digital rectal exams
4) Fecal occult blood tests
5) Sigmoidoscopies
6) Double contrast barium enemas (DCBE)
7) Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
8) Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If You need a routine gynecological exam performed as part of a cancer screening, You may go directly to a Network Provider who is an OB, GYN or OB/GYN.

Prenatal care
Covered services include Your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:
- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at Your Physician's, PCP's, OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under Coverage for *Maternity Hospital Stay and Well Newborn Care* and the *exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services
Covered services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when You get it in an individual or group setting. Your plan will cover this counseling only when You get it from a certified lactation support Provider.

Breast feeding durable medical equipment
Covered services and supplies include renting or buying durable medical equipment You need to pump and store breast milk as follows:

- **Breast pump**
  Covered services include:
  - Renting a Hospital grade electric pump while Your newborn Child is confined in a Hospital.
  - The buying of:
    - An electric breast pump (non-Hospital grade). Your plan will cover this cost once every three years, or
    - A manual breast pump. Your plan will cover this cost once per pregnancy.

  If an electric breast pump was purchased within the previous three-year period, the purchase of another electric breast pump will not be covered until a three-year period has elapsed since the last purchase.

- **Breast pump supplies and accessories**
  Covered services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

  Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment You purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives
Covered services include family planning services such as:

- **Counseling services**- counseling services provided by a Physician, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when You get them in either a group or individual setting.
- **Devices**- contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a Physician during an office visit.
- **Voluntary sterilization-** charges billed separately by the Provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

PRIVATE DUTY NURSING CARE
Private Duty Nursing care by a licensed Nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent: **Outpatient Nursing Care**. Charges are covered only when care is Medically Necessary and Appropriate and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown above, under Home Health Care Services and Supplies. Outpatient Private Duty Nursing care on a 24-hour-shift basis is not covered.

PROSTHESES (see "Durable Medical Equipment").

PROSTHETIC APPLIANCES
Charges for the initial provision and subsequent replacement of a Prosthetic Appliances that Your Physician orders and administers.
Prosthetic Appliances means:
1) A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

Coverage includes:
1) Repairing or replacing the original device You outgrow or that is no longer appropriate because Your physical Condition changed
2) Replacements required by ordinary wear and tear or damage

3) Instruction and other services (such as attachment or insertion) so You can properly use the device

ROUTINE PATIENT COSTS FOR PARTICIPATION IN AN APPROVED CLINICAL TRIAL

Charges for any Medically Necessary and Appropriate services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV Clinical Trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or Condition, as defined under the ACA, provided:

1) The Clinical Trial is approved by any of the following:
   a) The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
   b) The National Institute of Health.
   c) The U.S. Food and Drug Administration.
   d) The U.S. Department of Defense.
   e) The U.S. Department of Veterans Affairs.
   f) An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2) The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1) The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2) The cost of a service that is not a Healthcare service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4) A cost associated with managing an Approved Clinical Trial.
5) The cost of a Healthcare service that is specifically excluded by the Plan.
6) Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

SECOND OPINION CHARGES

The Plan covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, the Plan covers charges for a third opinion. The Plan covers such charges if the Practitioners who give the opinions:

1) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
2) are not business associates of the Practitioner who recommended the Surgery; and
3) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

SKILLED NURSING CARE

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.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including

charges for sleep apnea monitors.

SPECIALIZED INFANT FORMULAS

The Plan covers specialized non-standard infant formulas to the same extent and subject to the same terms and Conditions as coverage is provided under this Plan for Prescription Drugs. The Plan covers specialized non-standard infant formulas provided:

1) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula
   to be Medically Necessary and Appropriate; and
2) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The Plan may review continued Medical Necessity and Appropriateness of the specialized infant formula.

SUPPLIES TO ADMINISTER PRESCRIPTION DRUGS

The Plan covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

SURGICAL/MEDICAL SERVICES. The professional services of a Physician for surgical or medical services.

SURGICAL TREATMENT OF MORBID OBESITY

Coverage for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and the Plan authorizes coverage for such multi-stage procedure.

Covered expenses shall include charges for surgical treatment of Morbid Obesity for Covered Persons if the member meets specific Medical Necessity and Appropriateness criteria set forth by the plan. These covered expenses are covered when there are health problems that are aggravated by or related to the following but not limited to:

1) Type 2 diabetes,
2) Heart disease,
3) Pulmonary hypertension,
4) Obstructive sleep apnea.

In order for weight loss procedures to be covered they must meet the criteria for Medical Necessity and Appropriateness. The procedures that are generally covered will include all of the following.

1) Gastric bypass procedures,
2) Gastric banding procedures, (Lap Band, Realize Band, band fills)
3) Vertical banded gastroplasty,
4) Duodenal switch,
5) Gastric sleeve procedures.
6) Part of getting a Lap Band or Realize Band entails regular filling of Your band to adjust its tightness and Your ability to lose weight accordingly. If the Plan covers and pays for Your gastric banding procedure, then they will also cover the required band fills while getting used to Your band.

These services require Medical Precertification.

Other Considerations

In addition, the plan will cover treatment as a result of complications that may arise from surgical treatment of Morbid Obesity. For the purpose of this coverage, Morbid Obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high-risk comorbid Condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared. Utilizing a Bariatric Center of Excellence is preferred. Choosing an In-Network Provider is generally Your best course of action as well. When You choose an In-Network surgical Provider You will find lower out-of-pocket costs, meaning that You will pay less in the end when it comes to this type of procedure. Make sure that You consult with Your health plan directly for Medical Precertification. The sooner You begin to document Your weight loss journey, the sooner You can undergo the weight loss Surgery that You need.

Typically, procedures that may be associated with the gastric bypass that are cosmetic are not covered. An example is removal of the dense layer of fatty tissue growth, consisting of subcutaneous fat in the lower abdominal area. This procedure is called a Panniculectomy.

TELEPHONE CONSULTATIONS (TELEHEALTH AND/OR TELEMEDICINE)

If a Network Provider provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117, We cover such Network Provider's charges for services provided

through Telehealth and/or Telemedicine. The benefits are available for non-Emergency medical issues when Your Physician is not available. The services are provided by board-certified primary-care doctors and pediatricians by secure video, phone or e-mail and are available 365 days a year, 24 hours a day while at home, traveling or at work.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

The Plan covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) or Myofascial Pain Syndrome in a Covered Person. However, with respect to coverage of TMJ the Plan does not cover any charges for orthodontia, crowns, bridgework, or Prosthetic Appliances prescribed by a Physician or Dentist or treatment to alter vertical dimension or to restore abraded dentition. This limitation shall apply whether treatment is provided by a Hospital, Physician, Dentist, physical therapist or oral surgeon.

THERAPY SERVICES

The following are covered services or supplies ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

1) **Autism -** Medically Necessary and Appropriate Physical therapy, Occupational Therapy and Speech Therapy for the **treatment of autism or another Developmental Disability**. Additionally, expenses incurred for Medically Necessary and Appropriate behavioral interventions based on the principles of **applied behavioral analysis (ABA)** and related to structured behavioral programs for the treatment of autism in Dependents are covered.
   Benefits are provided for:
   a) Children who are being or who will be screened and/or diagnosed for autism or another Developmental Disability (as defined below); and
   b) Children who have a primary diagnosis of autism or another Developmental Disability. Coverage includes:
   a) Expenses incurred in screening and diagnosing autism or another Developmental Disability;
   b) When the Dependent's primary diagnosis is autism or another Developmental Disability, expenses incurred for Medically Necessary and Appropriate occupational therapy, Physical Therapy and Speech Therapy, when prescribed as part of a treatment Plan;
   c) Coverage of the above therapies will be covered even if the treatment is not restorative;
   d) When the primary diagnosis is autism, expenses incurred for Medically Necessary and Appropriate behavioral interventions based on the principles of applied behavioral analysis and related to structured behavioral programs, when prescribed as part of a treatment Plan;
   e) Benefits listed in item d) above will not be denied on the basis that the treatment is not restorative;
   f) Benefits listed in item d) above shall be provided to the same extent as those for any other medical Condition covered by the Plan, but shall not be subject to the limits on the number of visits that a Covered Person may make to a Provider of behavioral interventions;

   For such coverage to be in effect, it is necessary for the Covered Person to obtain a treatment Plan from the Dependent's Physician and to submit that Plan to the Plan Administrator. Failure to submit an appropriate treatment Plan will delay coverage. The treatment Plan shall include all elements necessary for the Plan to appropriately provide benefits, including but not limited to:
   a) A diagnosis;
   b) Proposed treatment by type, frequency and duration of service;
   c) The anticipated outcomes, stated as goals;
   d) The frequency by which the treatment Plan will be updated. The Plan Administrator may only request an updated treatment Plan every six months from the treating Physician in order for it to review Medical Necessity and Appropriateness, unless the Plan Administrator and the treating Physician agree that a more frequent review is necessary due to emerging clinical circumstances; and
   e) The treating Physician's signature.

   The term "Developmental Disability" means a severe, chronic disability of a person which:
   a) is attributable to a Mental Health Conditions or physical impairment or combination of Mental Health Conditions 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.

2) **Cardiac Rehabilitation Therapy -** program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.
3) **Chelation Therapy** - the administration of Drugs or chemicals to remove toxic concentrations of metals from the body.
4) **Chemotherapy –** the treatment of malignant disease by chemical or biological antineoplastic agents. The materials and services of technicians are included.
5) **Cognitive Rehabilitation Therapy -** retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic processes. Therapy must be by a licensed psychologist. Therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration to improve cognitive skills.
6) **Dialysis Treatment -** the treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
7) **Infusion Therapy -** the administration of antibiotic, nutrients or other therapeutic agents by direct infusion.
8) **Occupational Therapy -** treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Therapy must be by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
9) **Physical Therapy -** the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb. Treatment is covered by a licensed physical therapist. The therapy must be in accordance with a Physician's exact orders as to type, frequency and duration and to improve a body function.
10) **Radiation Therapy -** the treatment of disease by X-ray, radium, cobalt, or high-energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy. The materials and services of technicians are included.
11) **Respiration Therapy** - the introduction of dry or moist gases into the lungs.
12) **Speech Therapy -** treatment by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) Surgery for correction of a congenital Condition of the oral cavity, throat or nasal complex (other than a frenectomy of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Health Conditions.

TRANSPLANT BENEFITS

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational" and performed by an institution approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Medical Precertification is required.
Covered Charges include transplant services provided by a Physician and Hospital.
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

Network of Transplant Facilities

The amount You will pay for covered transplant services is determined by where You get transplant services. You can get transplant services from:

Institutes of Excellence™ (IOE) facilities The Plan designate to perform the transplant You need:

- A Non-IOE Facility that is approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.
- Your cost share will be lower when You get transplant services from the IOE Facility The Plan designate to perform the transplant You need. You may also get transplant services at a non-IOE Facility, but Your cost share will be higher.

The National Medical Excellence Program® (NME) will coordinate all solid organ, autologous bone marrow and associated dose intensive chemotherapy only for treatment of leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders, SCID (Severe combined immunodeficiency), and WISCOT Aldrich.

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- Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of Your transplant. While Your transplant care is being coordinated by the NME Program, all medical services must be

managed through NME so that You receive the highest level of benefits at the appropriate Facility. This is true even if the covered service is not directly related to Your transplant.

Charges for the care and treatment due to an organ or tissue transplant are covered, subject to the following limits:

1) The transplant must be performed to replace an organ or tissue.
2) Charges for obtaining donor organs are Covered Charges under this Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her Plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
    a) evaluating the organ;
    b) removing the organ from the donor; and
    c) transportation and storage costs directly related to the donation of the organ and billed by the Hospital.
3) If the organ donor is a Covered Person and the recipient is not, then this Plan will cover donor organ charges for:
    a) evaluating the organ, and
    b) removing the organ from the donor.

VISION CARE

Adult Vision Care Benefits

The Plan's network includes vision care Providers. You will receive coverage only if You visit an In-Network Provider for care.

The Plan covers the following services and supplies when provided by an In-Network vision care Provider at his or her office:

1) complete vision examination with refraction, limited to one Routine examination per Benefit Year
2) Initial contact lenses or glasses required following cataract Surgery.

Pediatric Vision Benefits (0-18 YEARS)

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Benefit, the Plan covers the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19. The Plan covers one comprehensive eye examination by an In-Network ophthalmologist or optometrist in a 12-month period.

The Plan covers one pair of lenses, for glasses or contact lenses, in a 12-month period. The Plan covers one pair of standard frames in a 12-month period. Standard frames refer to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

The Plan covers charges for one comprehensive low vision evaluation every 5 years. The Plan covers low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery. Such care shall include, but is not limited to:

1) Physician services
2) Hospital services
3) Circumcision

WIGS

The Plan will allow for the coverage of a wig or hairpiece prescribed by a Physician as a Prosthetic Appliance for hair loss due to Injury, disease, or treatment of a disease. The Plan covers 1 wig per calendar year.

Examples of covered Illnesses are:

1) Alopecia areata with near complete or complete cranial hair loss
2) Alopecia totalis
3) Alopecia universalis
4) Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia
5) Chemotherapy
6) Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss
7) Lupus
8) Radiation therapy

The Plan will review all replacement requests for wigs on a case by case basis.

The Plan does not cover the replacement of a wig, as applicable, in the case of any of the following, as they are not the result

of a medical disorder:

1) Damage incurred to the wig as a result of color dying
2) Damage incurred to the wig as a result of a permanent treatment application

WILM'S TUMOR

The Plan pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. The Plan treats such charges the same way the Plan treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard Chemotherapy treatment is unsuccessful. The Plan pays benefits for this treatment even if it is deemed Experimental or Investigational. What the Plan pays is based on all of the terms of this Plan.

DENTAL BENEFITS

If You are enrolled in a dental Benefit Plan offered separately through the Plan, please refer to the SPD for Your particular Benefit Plan located on the Plan's website or call the Plan to request a hard copy. For dental benefits covered under the medical/prescription Benefit Plans, please refer to page 27.

PRESCRIPTION DRUG BENEFITS

The following Prescription Drug Benefit Section applies for all medical plans that have elected Prescription Coverage. Please contact Your Employer to see which Rx Option You are enrolled in.

REFER TO ATTACHED SCHEDULE OF BENEFITS FOR DETAILED PLAN DESIGN COMPONENTS AND TO HTTP://WWW.EXPRESS-SCRIPTS.COM/APEHP FOR PRESCRIPTION COST ESTIMATOR.

Express Scripts is the Prescription Plan Claims Administrator of the Pharmacy drug plan. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

How does my prescription plan work?

Prescription ID cards will be mailed directly to Your home from **Express Scripts**. Just present Your ID card to Your pharmacist when You fill a prescription. Chances are Your Pharmacy already participates in the network. The card contains all the information Your pharmacist needs, there is nothing else that You need to do and no claim forms to submit. You will be asked to pay the retail pharmacist Your co-payment or Deductible amount as detailed in the Schedule of Benefits for Your Plan.

1) **Retail quantities** dispensed will be as written on the previous prescription order or refill, to a maximum of a 90-day supply, Copayment is based on the multiple of the 30-day supplies received.
2) **Mail Order quantities** dispensed will be as written on the previous prescription order or refill, to a maximum of a 90-day supply.

What are my Copayments for Prescription Drugs?

The Copayment and/or Deductible is applied to each covered Pharmacy drug charge and is shown in the Prescription Benefit Plan Summary at the end of the Schedule of Benefits. The Copayment and/or Deductible amount is not a covered charge under the Medical Plan.

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1) Refills only up to the number of times specified by a Physician.
2) Refills up to one year from the date of order by a Physician.

If a drug is purchased from a non-participating Pharmacy, or a Participating Pharmacy when the Covered Person's ID card is not used, the amount payable by the Covered Person in excess of the Copayment will be the ingredient cost and dispensing fee.

How can I obtain prescriptions by mail?

If You are taking Drugs for the treatment of a chronic Condition on a long-term basis You may wish to consider the convenience and savings offered by the Mail Order Pharmacy. Up to a 90-day supply may be obtained on a non-Emergency basis through Mail Order. The medication can be shipped directly to Your home. You will be required to pay the co-payment as outlined previously; the Plan will pay the remainder of the cost of Your prescription. Information on the Mail Order Pharmacy and instructions for use are included with Your Welcome Package from Express Scripts, or You may call the number listed on the back of Your identification card.

Preferred Formulary List

Your Preferred Formulary List is intended to serve as a voluntary guide in selecting clinically and therapeutically appropriate medications in a cost-effective manner. It is not intended to set a standard of care, nor is it intended to take the place of a Physician's or pharmacist's judgment with regard to a patient's pharmaceutical care. Information on the preferred medications is provided in the Preferred Formulary List. Additional copies of the List can be obtained by calling the number on the back of Your identification card. We suggest You review this information and show the Preferred Medication list to Your Physician. If You wish to take advantage of the cost savings available to You, ask Your Physician to prescribe medications from this list whenever appropriate. Your Physician may want to keep a copy of the List with Your medical file to facilitate future prescribing.

Formulary Exception Process

From time to time, Express Scripts may make changes to their formulary and may eliminate coverage for products from their National Preferred Formulary. The list of non-covered Drugs and their alternatives are available on www.express-scripts.com. Covered Persons and their Physicians should review the preferred alternative products and consider switching to one of them.

If the Covered Person's Physician can demonstrate that the excluded medication is the only product that is clinically appropriate, the Physician should contact Express Scripts at 1.800.753.2851 to start the formulary exception process. Criteria for exceptions are based on: clinical recommendations, treatment guidelines, and evidence-based literature.

1) If the exception is approved, Express Scripts notifies the Covered Person and Physician.
2) If Express Scripts requires more information, a representative will contact the Physician.
3) If the exception is denied, Express Scripts notifies the Covered Person and Physician.

Should a denial occur, the reason(s) for the denial will be included in the communication from Express Scripts. Information regarding appeal rights is also provided along with the necessary steps to make such a request.

Coverage of New Drugs

The drug formulary list (list of Preferred Drugs) was developed by the PBM "Committee" which is a panel of Physicians and pharmacists. The Committee regularly reviews and updates the formulary based on the latest information available about each drug's effectiveness.

All newly approved Drugs are designated non-formulary/non-preferred until the Committee evaluates the drug clinically and considers whether it should be placed on the formulary. Drugs that represent an advance over an available therapy according to the Federal Drug Administration (FDA) will be reviewed by the Committee within six months after FDA approval. Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a drug.

What about generic Drugs?

You will always enjoy the lowest possible co-pay by using generic equivalent medications. If You wish to take advantage of this savings opportunity, ask Your Physician to prescribe Your medication generically. This will enable Your pharmacist to supply the generic equivalent when one is available. You may also consult with Your pharmacist regarding Generic Drug options for any brand name medication You are currently taking.

How to find a participating Pharmacy?

To locate the nearest participating Pharmacy, obtain information about Your coverage, or to obtain assistance with service related matters, feel free to contact the number on the back of Your identification card. When inquiring, have Your identification card ready, which contains Your Plan Sponsor name and personal identification number. Service representatives who know Your Plan design are available 7 days a week; 24 hours a day.

What happens if I use a Out-of-Network Pharmacy?

It is to Your advantage to use a participating Pharmacy. In the rare event that You go to a non-Participating Pharmacy or are unable to provide Your pharmacist with the necessary eligibility information, You may manually submit a Direct Reimbursement Claim Form. Be sure to obtain a complete Prescription Drug receipt which includes the amount charged, prescription number, name of drug dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. You will be reimbursed only if the drug is covered under the program and for only the amount that would have been paid to the participating Pharmacy, minus any applicable co-payment. This amount may be significantly lower than the retail price You paid.

What if I need Specialty Medications?

Specialty Medications are Drugs that are used to treat complex Conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. You must use our dedicated specialty Pharmacy, Accredo Health Group, Inc., in order to have coverage for Specialty Medications. Accredo Health Group, Inc., an Express Scripts specialty Pharmacy, is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

Whether Your Specialty Medications are administered by a healthcare professional, self-injected or taken by mouth, Specialty Medications require an enhanced level of service. By ordering Your Specialty Medications through Accredo, You can receive:

1) Toll-free access to specialty-trained pharmacists and Nurses 24 hours a day, 7 days a week
2) Expedited, scheduled delivery of Your medications at no additional charge
3) Necessary supplies, such as needles and syringes, provided with Your medications

4) Safety checks to help prevent potential drug interactions
5) Refill reminders
6) Health and safety monitoring
7) Up to a **90-day supply** of Your Specialty Medication for just one co-payment.

For more information about Accredo, or to order Your Specialty Medications, please call the number on Your ID card.

Coverage Management Programs

Under this plan, Express Scripts is required to review prescriptions for certain medications with Your doctor before they can be covered. There are three Coverage Management programs under Your plan: Prescription Precertification, Qualification by History, and Quantity Management. These are in place to help the Plan to continue providing affordable healthcare options. Contact Express Scripts to determine if You or a family member is taking a Prescription Drug that may require review or Prescription Precertification in order for them to be covered by Your plan.

1) Prescription Precertification. Some medications require that You obtain approval through a coverage review before the medication can be covered under Your plan. The coverage review process for Prescription Precertification will allow Express Scripts to obtain more information about Your treatment (information that is not available on Your original prescription) in determining whether a given medication qualifies for coverage under Your plan.
2) Qualification by history. Some medications may also require a coverage review based on:
   a) Whether certain criteria have been met, such as age, sex, or Condition; and/or,
   b) Whether treatment of an alternate therapy or course of treatment has failed or is not appropriate.
   c) In either of these instances, Express Scripts pharmacists will review the prescription to ensure that all criteria required for a certain medication have been met. If the criteria have not been met, a coverage review will be required. If so, Express Scripts will automatically notify the pharmacist, who will in turn tell You that the prescription needs to be reviewed for Prescription Precertification. If You know in advance that Your prescription requires a coverage review, ask Your doctor to call Express Scripts before You go to the Pharmacy.
3) Quantity management. To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on product labeling or clinical guidelines and are subject to periodic review and change. Examples include anti-migraine Drugs, rheumatoid arthritis and osteoarthritis Drugs, impotence Drugs, sleep aids, and pain management Drugs.
4) Other programs may exist. For more information, call the toll-free number on Your ID card. Once Your coverage begins, You can access information about Your Plan and claims history, price Your medications and more at Your customized website, express-script.com.

If a coverage review is required

To arrange a review, You, Your doctor, or pharmacist should call Express Scripts at the number listed on Your ID card, 8:00 a.m. to 9:00 p.m., Eastern time, Monday through Friday. If Prescription Precertification is not obtained, You will be responsible for the full cost of the medication at retail. If You mail in the prescription to the Medco Pharmacy, Your prescription will be returned unfilled. If coverage is approved, You will pay Your normal Copayment or Coinsurance for the medication.

Maintenance Medication (90-day supply) and Home Delivery Program – Walgreens Smart 90 Program.

You'll pay more for Your long-term Drugs (such as those used to treat high blood pressure or high cholesterol) unless You use a Walgreens Pharmacy or order Your prescriptions through the mail by using the **Mail Order Pharmacy**. The first **two times** that You purchase a long-term drug at a participating retail Pharmacy, You'll pay Your retail co-payment. After the **second purchase**, You'll pay a **higher cost** if You continue to purchase maintenance medications in a 90-day supply at any retail pharmacy except Walgreens. To avoid paying more, use a Walgreen's Pharmacy or the **Mail Order Pharmacy** and pay Your mail-order co-payment for up to a 90-day supply. If the cost of a medication at a retail Pharmacy is lower than Your plan's retail co-payment, You will not pay more than the retail Pharmacy's cash price, regardless of the number of times You purchase the medication. In some cases, this price may be less than either Your standard retail or mail co-payment.

Dispense as Written (DAW) Program

This program allows Covered Persons to save by using Generic Drugs by automatically filling Your prescription with the low-cost generic alternative to save both You and the Plan. If You or Your Physician request the brand-name mediation when a generic equivalent is available, You will pay the applicable co-payment, plus the difference in cost between the brand and the generic.

SaveonSP Program

SaveonSP Program- The Plan is partnering with Express-Scripts' program, SaveonSP effective 10/1/18, a specialty Pharmacy Copayment assistance program. By participating in this program, select Specialty Medications will be free of charge ($0). Your prescriptions will still be filled through Accredo, Your existing specialty mail pharmacy. Certain specialty Pharmacy drugs are considered non-essential health benefits under the Plan and the cost of such drugs will not be applied toward satisfying the participant's Maximum Out-of-Pocket (drug list can be found at www.membershealthplannj.com under pharmacy); although

the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant; and Copayments for certain Specialty Medications may be set to the max of the current plan design or any available manufacturer-funded Copayment assistance. The program currently targets 150+ specialty drugs in 10 therapy classes: Asthma & Allergy, Blood Cell Deficiency, Cystic Fibrosis, Hemophilia, Hepatitis C, Hereditary Angioedema, Inflammatory, Oncology, Multiple Sclerosis, Pulmonary Arterial Hypertension. Letters will be sent to impacted members on non-HSA plans to voluntarily enroll those individuals in the program. To enroll, simply call SaveonSP at 1-800-683-1074. If You choose not to participate, You will be responsible for an increased Copayment for select medications. Keep in mind that the Copayment will not count towards Your Deductible or Maximum Out-of-Pocket.

Which Drugs are covered?

Your prescription Plan covers most Medically Necessary and Appropriate Federal Legend, State Restricted and Compounded Medications, which by law may not be dispensed without a prescription order. An abbreviated summary of the exclusions to this are listed below. Your pharmacist has on line access to Your Plan design information and can readily see which Drugs are covered under Your plan, or You can contact our Member Services center to inquire about coverage for a specific drug. Prescription Drug programs do not cover any over the counter Drugs, medical supplies or devices even if purchased at a Pharmacy, and even if a prescription order is written.

Which Prescription Drugs are not covered? Refer to the Plan Exclusion section of this document for a list of Prescription Drugs that are not covered under the Plan.

Prescription Appeals:

Stage 1 Appeal: In the event You receive an Adverse Benefit Determination following a request for coverage of a prescription benefit claim, You have the right to appeal the Adverse Benefit Determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate an appeal for coverage, provide in writing Your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to **Express Scripts., 8111 Royal Ridge Parkway, Irving, TX 75063.** A decision regarding Your appeal will be sent to You within 15 days of receipt of Your written request. The decision will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the Plan in relation to Your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to receive, upon request and at no charge, the information used to review Your appeal.

Stage 2 Appeal: If You are not satisfied with the coverage decision made on appeal, You may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate a second level appeal, provide in writing Your name, member ID, phone number, the Prescription Drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to **Express Scripts, 8111 Royal Ridge Parkway, Irving, TX 75063.** You have the right to review Your file and present evidence and testimony as part of Your appeal, and the right to a full and fair impartial review of Your claim. A decision regarding Your request will be sent to You in writing within 15 days of receipt of Your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to Your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review Your second level appeal. If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final Adverse Benefit Determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal or Your Adverse Benefit Determination notice or final Adverse Benefit Determination notice does not contain all of the information required under ERISA, You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review

will be described in any notice of an Adverse Benefit Determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving Urgent Care, You will be notified of the benefit Determination within 24 hours of receipt of the claim. An Urgent Care claim is any claim for treatment with respect to which the application of the time periods for making non- Urgent Care Determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, You will be notified within 24 hours after receipt of Your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If You don't provide the needed information within the 48-hour period, Your claim will be deemed denied.

You have the right to request an urgent appeal of an Adverse Benefit Determination (including a deemed denial) if You request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or Your Physician may call 800-864-1135 or send a written request to **Express Scripts., 8111 Royal Ridge Parkway, Irving, TX 75063, Attn: Urgent Appeals**. In the case of an urgent appeal for coverage involving Urgent Care, You will be notified of the benefit Determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review Your appeal. If new information is received and considered or relied upon in the review of Your appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final Adverse Benefit Determination of this appeal. The decision made on Your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if Your appeal is denied or Your Adverse Benefit Determination notice or final Adverse Benefit Determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize Your life or health or Your ability to regain maximum function, You could have the right to immediately request an expedited external review prior to exhausting the internal appeal process, provided You simultaneously file Your request for an internal appeal of the Adverse Benefit Determination. Details about the process to initiate an external review will be described in any notice of an Adverse Benefit Determination.

PLAN EXCLUSIONS

The following Plan Exclusions apply for **all Benefit Plans** offered.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Section of this document.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Acupuncture. Except when used as a substitute for other forms of anesthesia or pain management when Medically Necessary and Appropriate.

Alternative Therapies/Complementary Medicine. Environmental ecological treatments, primal therapy, bioenergetic therapy, carbon dioxide therapy, hair analysis, hypnosis and hypnotherapy, massage therapy, except when used as a physical therapy modality, sensory or auditory integration therapy, music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements (except for medical foods and except as provided under Inherited Metabolic Disease and Specialized Infant Formulas) and therapy; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy and treatment programs; educational therapy; obesity control therapy.

Ambulance services for transportation from a Hospital or other health Facility, unless You are being transferred to another Inpatient health care Facility, including Ambulance service to home or after discharge.

Armed Forces. Services or supplies received as a result of a ***war*** or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.

Blood, Blood Products that are donated or replaced on behalf of the Covered Person.

Childbirth classes are not a covered benefit under the Plan.

Christian Science Practitioner. Care and treatment by a Christian Science Practitioner are not covered.

Clinical Trial. The Plan does not cover Clinical Trials, except as described under Cancer Clinical Trials and Clinical Trials.

Completion of claim forms.

Complications of non-covered treatments. Care, services or treatment required as a result of complication from a treatment not covered under the Plan.

Confined Persons. Charges for services, supplies, and/or treatment of any Covered Person that were Incurred while confined and/or arising from confinement in a prison, jail, or other penal institution with said confinement exceeding 72 consecutive hours.

Cosmetic Services and Plastic Surgery. Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including but not limited to, the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities.

Counseling. Counseling services that are not Medically Necessary and Appropriate in the treatment of a diagnosed medical Condition, including, but not limited to: educational counseling, vocational counseling, career counseling, counseling for social or social-economic purposes, stress management, social adjustment, lifestyle modification, religious counseling, pastoral, marriage counseling and financial counseling services.

Court Ordered Treatment. Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding. This exclusion does not apply to otherwise Covered Services due to a qualified medical Child support order.

Covered under another law. Services provided for the treatment of any Condition, disease, Illness or Injury that's covered under any Workers' Compensation Law, Occupational Law, Occupational Disease Law, or any similar law.

Custodial Care. Services or supplies provided mainly as a rest care, maintenance or Custodial Care.
Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting You
- Respite care, adult (or Child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental Service & Appliances. Dental care or treatment including appliances and dental implants, except as otherwise stated under Dental Services in the Summary of Covered Services and Supplies.

Diagnostic Testing. Diagnostic testing in connection with school exams, athletic exams, pre-marital exams or employment physicals are not covered except as otherwise stated under the Preventive Care Services for Adults and Children in the Summary of Covered Services and Supplies.

Dose Intensive Chemotherapy. Refer to covered services that address chemotherapy.

Early intensive behavioral interventions. Examples of those services are early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions. This exclusion does not include ABA Therapy – behavioral interventions based on the principles of applied behavioral analysis (ABA) and related to structured behavioral programs for the treatment of autism.

Education/Vocational Training or Testing. Charges for educational or special education schooling or any such related or similar program, remedial education, wilderness treatment programs, job training, job hardening programs, whether or not given in a Facility providing medical or psychiatric care. Services for educational or vocational testing or training except diabetic self-education as provided under Diabetic Services Supplies and Training.

Elective Ambulance. Including Ambulance service to home or after discharge.

Excess Charges. Charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Plan's Allowable Charges. This shall include charges that are in excess of the Plan's Allowable Charges or are for services not deemed to be Reasonable and Customary or Medically Necessary and Appropriate, in the Plan Administrator's Discretion which is subject to the appeals process.

Exercise Programs. Exercise programs for treatment of any Condition, except for Physician-supervised cardiac rehabilitation, occupational or Physical Therapy covered by this Plan.

Experimental or Investigational drugs, devices, treatments or procedures are not covered unless specified as a covered service in the Summary of Covered Services and Supplies or unless covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). If any Experimental or Investigational services or supplies are provided in the course of a Clinical Trial, some routine patient costs for items and services furnished in connection with participation in a Clinical Trial may be covered, but only if those items and services would otherwise be provided under the Plan.

Routine costs do not include any of the following:

a) The Experimental/Investigational drug, biological product, device, medical treatment or procedure itself.
b) The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

c) The services and supplies customarily provided by the research sponsor free of charge for any enrollee in the Clinical Trial.

Extraction of Teeth. Except for bony impacted teeth.

Eye Care. All procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty or other eye Surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, unless such care is specified as a covered service in the Summary of Covered Services and Supplies. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Facility charges. For care, services or supplies provided in Rest homes, assisted living facilities, similar institutions serving as a persons' main residence or providing mainly custodial or rest care, health resorts, spas or sanitariums, infirmaries at schools, colleges, or camps.

Foot Care. Services and supplies for the treatment of calluses, bunions, toenails, hammertoes, or fallen arches, the treatment of weak feet, chronic foot pain or Conditions caused by routine activities, such as walking, running, working or wearing shoes, supplies (including orthopedic shoes), foot Orthotic Appliances, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails, unless such care is specified as a covered service in the Summary of Covered Services and Supplies.

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 Precertification process**,** 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 Precertified by the Plan are Non-Covered Charges.

Gastric Bypass, Lap Band Surgery or Weight Loss Surgery. Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity except as provided under Surgical Treatment of Morbid Obesity. Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery, surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity, drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications, hypnosis or other forms of therapy, exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Government Coverage. Charges for care, supplies, treatment, and/or services that the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, or to services eligible for payment under Medicaid and Medicare.

Government-Operated Facilities. Charges for care, supplies, treatment, and/or services that meet the following requirements:

a) That are furnished to the Covered Person in any veteran's administration Hospital, military Hospital, Institution or Facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
b) That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: *This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.*

Growth/height care. A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, surgical procedures, devices and growth hormones to stimulate growth that is not Medically Necessary.

Hair Loss. Care and treatment for hair loss including wigs, hair transplants, hair weaving or any drug that promises hair growth, whether or not prescribed by a Physician. This exclusion does not apply to wigs due to Injury, disease or treatment of a disease.

Hazardous Pursuit, Hobby or Activity. Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity for cash compensation or prize money. A hobby or activity is hazardous if it is an unusual activity which is categorized by a constant threat of danger or risk of bodily harm. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical Condition (including both physical, Mental Health Conditions and Substance Use Disorders or Conditions).

Health Awareness. Dietary instruction, educational services, behavior modification, literature, membership in health clubs, exercise equipment, and preventive programs other than those specifically listed as covered in the Summary of Covered Services and Supplies.

Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting including cochlear electromagnetic hearing devices; and, routine hearing examinations, with the exception of Medically Necessary and Appropriate hearing aids for Children under the age of 16. Services and supplies related to these items are not covered. This exclusion does not apply to screening for newborn hearing loss and monitoring of infants for delayed onset of hearing loss. This exclusion does not apply to those services specifically listed as covered in the Summary of Covered Services and Supplies: Hearing Aids, Preventive Care Services for Adults and Children, and Well Newborn Care.

Herbal Medicine.

In regard to **Hospice Care:**

a) Research studies directed to life lengthening methods of treatment;
b) Expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property).

Hospital Employees. Professional services billed by a Physician or Nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

Housekeeping. Charges for housekeeping services.

Hypnotism.

Illegal Acts. Charges for care, supplies, treatment, and/or services that are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical Condition (including both physical, Mental Health Conditions and Substance Use Disorders or Conditions).

Illegal Drugs or Medications. Charges that are for services, supplies or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of illegal Drugs or medications. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorders treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical Condition (including both physical, Mental Health Conditions and Substance Use Disorders or Conditions).

Immunizations required for employment, or travel.

Incurred by Other Persons. Charges that are expenses actually Incurred by other persons.

Infertility Services. Services or supplies furnished in connection with any procedures to enhance *fertility* which involve harvesting, storage and/or manipulation of eggs and sperm. This includes all exclusions listed under Fertility Services in Summary of Covered Services and Supplies. See also the separate Exclusion addressing sterilization reversal.

Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and Appropriate or not Custodial in nature and the Hospital's Intensive Care Unit is filled, or the Hospital has no Intensive Care Unit.

Medically Necessary and Appropriate. Charges for care, supplies, treatment, and/or services that are not Medically Necessary and Appropriate and/or arise from care, supplies, treatment, and/or services that are not Medically Necessary and Appropriate.

Medicare. Charges for care, supplies, treatment, and/or services that are provided or which would have been provided had the Covered Person enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in this Plan. This exclusion does not apply to Covered Persons who meet the Working Aged provisions of the Medicare secondary payer rules.

Medication / Supplements. Excludes the following types of medication:

a) **Impotence.** Care, treatment, services, supplies or medication to treat sexual inadequacies or dysfunction.
b) **Herbal Medication.**
c) **Methadone Maintenance.** This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical Condition (including both physical, Mental Health Conditions and Substance Use Disorders or Conditions).
d) Medication furnished by any other medical service for which no charge is made to the Covered Person.
e) Outpatient Prescription Drugs and medications; medications that may be dispensed without a doctor's Prescription Order;
f) **Nutritional Supplements**, except when the Covered Person has no other source of nutritional intake due to a metabolic or anatomic disorder;

Medical supplies – outpatient disposable. Any outpatient disposable supply or device. Examples of these are- sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, other home test kits, splints, neck braces compress, other devices not intended for reuse by another patient. This exclusion does not apply to diabetic related supplies, see section Diabetic Services, Supplies and Training. This exclusion also does not apply to ostomy supplies, see section Ostomy Supplies in the Summary of Covered Services and Supplies.

Megavitamin Therapy and Orthomolecular Psychiatric Therapy.

Military and Armed Forces. Services for any Illness or Injury occurring during military service. Condition which results from participation in a civil insurrection, riot, duty as a member of the armed forces of any country or state of war (whether the war is declared or undeclared). Care related to military service disabilities and Conditions which the Covered Person is legally entitled to receive at government facilities which are not Network Providers, and which are reasonably accessible to the Covered Person.

Modification to a home or automobile to make it accessible and drivable by an individual with a disability.

Negligence. Charges for care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its Discretion, in light of applicable laws and evidence available to the Plan Administrator.

No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

No Coverage. Charges that are Incurred at a time when no coverage is in force for the applicable Covered Person.

Non-Mental Health Conditions. Services for or in connection with the following when not specifically the result of Mental Health Conditions: Social maladjustment, Behavior, Lack of discipline or other antisocial action. This exclusion does not apply if related to an Injury that (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical Condition (including both physical, Mental Health Conditions and Substance Use Disorders or Conditions).

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

Not specified as covered. Services, treatments and supplies which are **not specified as covered** under this Plan would be covered if determined to be Medically Necessary and Appropriate and not specifically excluded.

Obesity. Charges for weight reduction Surgery (unless Medically Necessary and Appropriate due to Morbid Obesity) or weight reduction programs including all Diagnostic Testing, weight control programs, charges for nutritional supplements, special diets (unless for medical food and low protein modified food products for inherited metabolic diseases when diagnosed and determined to be Medically Necessary and Appropriate by the treating Physician), vitamins, charges for Drugs or supplements for weight gain or loss.

Occupational. Care and treatment of an Injury or Sickness that is occupational-that is, arises from work for wage or profit including self-employment.

Organ Donor. Expenses for member donors donating organs to member recipients are covered only as described in Transplant Benefits under Summary of Covered Services and Supplies. No payment will be made for human organs which are sold rather than donated. The Plan does not cover costs for travel, accommodations or comfort items.

Orthodontic appliances.

Orthoptics, Vision training, low vision aids or supplemental training. Eye exercises are specifically excluded, because vision therapy, optometric training, eye exercises or orthoptics are considered Experimental and/or Investigational for any indication including the management of visual disorders and learning disabilities.

Out-of-Network or Out-of-Network Provider. Any service provided by an **Out-of-Network or Out-of-Network Provider** for Covered Persons enrolled in any benefit Plan with **no** Out-of-Network coverage, except for Urgent Care and Emergency care, and unless otherwise specified in this document. The following are not covered benefits when **provided by an Out-of-Network Providers** as described in the Schedule of Benefits:

a) Chiropractic Services/Spinal Manipulations
b) Durable Medical Equipment
c) Home Healthcare
d) Outpatient Elective Surgery at a free-standing surgical center (Facility charges in excess of $1,000 only)
e) Routine Podiatric Services
f) Routine Vision Care
g) Routine Preventive Care Services

Personal Comfort Items & Services. Any service or supply primarily for Your convenience and personal comfort or that of a third party for which any of the following statements are true and is not DME will not be covered. Any item:

a) **That is for comfort or convenience.** Items not covered include but are not limited to: massage devices and equipment; portable whirlpool pumps, and telephone alert systems; telephone; television; bed-wetting alarms; orthopedic mattress; non-Hospital adjustable beds; customized wheelchairs; and ramps.
b) **That is for environmental control.** Items not covered include but are not limited to: air cleansers/purification units; air conditioners; dehumidifiers; portable room heaters / electric heating units; and ambient heating and cooling equipment.
c) **That is inappropriate for home use.** This is an item that generally requires professional supervision for proper operation. Items not covered include but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; trans lift chairs; and any devices used in the transmission of data for Telemedicine purposes.
d) **That is a non-reusable supply or is not a rental type item,** other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include but are not limited to: blood pressure instruments; scales; elastic bandages; incontinence pads; lambs' wool pads; ace bandages; non-Prescription Drugs and medicines; first aid supplies; anti-embolism stockings; catheters (non-urinary); face masks (surgical); disposable gloves; sheets and bags; and irrigating kits. This does not apply to supplies used for the treatment of diabetes as described in the Diabetic Services, Supplies and Training section of the Summary of Covered Services and Supplies.
e) **That is not primarily medical in nature.** Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include but are not limited to: ear plugs; exercise equipment; ice pack; speech teaching machines; strollers; silverware/utensils; feeding chairs; toileting systems; toilet seats; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.
f) **That has features of a medical nature which are not required by the patient's Condition, such as a gait trainer.** The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists is a realistic feasible alternative item that serves essentially the same purpose and is Medically Necessary and Appropriate.
g) **That duplicates or supplements existing equipment for use when traveling or for an additional residence.** For example, a patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would not be

eligible for two identical items, or one for each living space.

h) **Which is not customarily billed for by the Provider.** Items not covered include but are not limited to: barber or beauty service and similar incidental services; delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.

i) **That modifies vehicles, dwellings, and other structures.** This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.

j) **Replacements or Repairs** of DME or Prosthetic Appliances the item due to abuse or loss**.**

k) **Home Health Care Services and Supplies**:

- Custodial services, food, housing, homemaker services, housekeeping, home delivered meals and supplementary dietary assistance;
- Provided by family members, relatives, and friends;
- A Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay;
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay), or as otherwise specified in the Home Health Care Services and Supplies provision;
- Visits by any Provider personnel solely for the purpose of assessing a Covered Person's Condition and determining whether or not the Covered Person requires and qualifies for Home Health Care Services and will or will not be provided services by the Provider.

Physical Examinations. For routine physical examinations not required for health reasons including but not related to, employment, insurance, government license, and court-ordered forensic or custodial evaluations. Also, for non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sport, other recreational activity or travel; and examinations for insurance, licensing and employment.

Plan design exclusions. Charges excluded by the Plan design as mentioned in Plan Exclusions and in the Schedule of Benefits.

Prescription Drugs. The following Prescription Drugs are not covered under the Plan:

1) Medications which do not require a prescription order, even if one is written, and medications which are not considered Medically Necessary and Appropriate for the treatment of an Injury or Sickness.
2) Medications, which are not prescribed in accordance with FDA, approved uses.
3) Any drug prescribed or dispensed in a manner contrary to normal medical practices.
4) Medications administered by a Physician or prescriber, and those not dispensed at a Pharmacy such as those You receive at Your doctor's office, in a Hospital, clinic or other care Facility.
5) Medications for which the cost is recoverable under a government program, worker's compensation, or occupational disease law.
6) Medications for which no charge is made to You.
7) Immunization agents, allergy sera, biological sera, and charges for the administration or injection of Drugs.
8) Any drug labeled "Caution - limited by Federal Law to Investigational Use" or Experimental Drugs, even though a charge is made to You.

The following categories of Prescription Drugs are <u>not covered under the Plan</u>:

1) Legend vitamins, except for Prenatal vitamins for Pregnancy
2) Any over the counter medications
3) Male sexual dysfunction Drugs
4) Medications prescribed for weight control purposes
5) Genetically engineered Drugs
6) Drugs prescribed for cosmetic purposes and hair loss medications
7) Needles, syringes, and injection devices (except with insulin)
8) Certain injectables, such as injectable forms of fertility, etc. (except prescription insulin)

Primal Therapy. Environmental ecological treatments, primal therapy, bioenergetic therapy, carbon dioxide therapy.

Psychodrama.

Reasonable and Customary. To the extent charges are in excess of the Reasonable and Customary charges.

Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, grandparent, Child, brother or sister, whether the relationship is by

blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical Condition to make the original device no longer functional.

Rest cures, sanatorium or convalescent care.

Rolfing. a technique of deep tissue manipulation aimed at the release and realignment of the body, and the reduction of muscular and psychic tension.

School System Coverage. Services or items any school system is required to provide.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

Services provided by a family member. Services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, grandparent, Child, brother or sister, whether the relationship is by blood or exists in law.

Sex change. Any treatment, drug, service or supply related to changing sex or sexual characteristics. Examples of these are- surgical procedures to alter the appearance or function of the body, hormones and hormone therapy, Prosthetic Appliances.

Sexual dysfunction and enhancement. Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including- surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Sleep Disorders. Care and treatment for sleep disorders unless deemed Medically Necessary and Appropriate.

Stand-by Services required by a provider**.**

Strength and performance. Services, devices and supplies such as drugs or preparations designed primarily for enhancing Your strength, physical condition, endurance, physical performance.

Supplements*.* Vitamins, minerals, food supplements or substitutes.

Support Items*.* Corsets and other support items.

Surgical sterilization and reversal of sterilization. Care and treatment for reversal of surgical sterilization.

Surrogacy. Fees incurred and maternity services for the Maternity services provided to a Gestational Carrier or Surrogate.

Telephone Consultations. Telephone consultations are excluded other than those covered under Telephone Consultations (Telehealth And/Or Telemedicine) section.

Timely Filing of Claims. Claims submitted after the 180th day following the date of service will not be considered eligible for coverage under this Plan and will be the responsibility of the Covered Person.

Transplants. Excepts as otherwise listed under Summary of Covered Benefits and Services.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for Ambulance charges as defined as a covered expense.

Umbilical Cord Preservation.

Veterans' administration Hospitals. Coverage for Veterans' administration Hospitals are covered only when services or treatment are for a non-service related Injury or non-service Emergency. Benefits will be payable based on the Provider's participation.

War. Services or supplies received as a result of a *war* or an act of war, if the Illness or Injury occurs while the Covered Person

is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.

Weight Reduction Programs/Surgery. Charges for weight reduction Surgery (unless Medically Necessary and Appropriate due to Morbid Obesity) or weight reduction programs including all Diagnostic Testing, weight control programs, charges for nutritional supplements, special diets (unless for medical food and low protein modified food products for inherited metabolic diseases when diagnosed and determined to be Medically Necessary and Appropriate by the treating Physician), vitamins, charges for Drugs or supplements for weight gain or loss.

Exercise Programs & Health Awareness. Exercise Programs for treatment of any Condition, except for Physician-supervised cardiac rehabilitation, occupational or Physical Therapy covered by this Plan. Dietary instruction, educational services, behavior modification, literature, membership in health clubs, exercise equipment, and preventive programs other than those specifically listed as covered.

Wigs, toupees, hair transplants, **hair weaving or any drug**, if such drug is used in connection with baldness (with the exception of wigs prescribed by a Physician as a Prosthetic Appliance for hair loss due to Injury, disease, or treatment of a disease).

Workers' Compensation Benefits. Any Sickness or Injury for which the Covered Person is paid benefits, or may be paid benefits if claimed, if the Covered Person is covered or required to be covered by Workers' Compensation. In addition, if the Covered Person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, the Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the Covered Person is covered by a Worker's Compensation program that limits benefits if other than specified health care Providers are used, and the Covered Person receives care or services from a health care Provider not specified by the program, the Plan shall not cover the balance of any costs remaining after the program has paid.

MEDICAL MANAGEMENT SERVICES

The following Medical Management guidelines and procedures apply for all benefit Plans offered. All of the following sections make up the Medical Management Review program.

MEDICAL NECESSITY AND APPROPRIATENESS

Healthcare services will be reviewed for Medical Necessity and Appropriateness. Medical Necessity and Appropriate healthcare services are services that a Provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1) In accordance with generally accepted standards of medicalpractice
2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
3) Not primarily for the convenience of the patient, Physician, or other health care Provider
4) Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

1) Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
2) Consistent with the standards set forth in this Plan issues involving clinical judgment.

MEDICAL PRECERTIFICATION

You need pre-approval from the Plan for some eligible health services. Pre-approval is also called Medical Precertification.

The patient, a family member or a Provider must call to receive Medical Precertification for certain services that are outlined on the Medical Precertification Requirement List. This call must be made at least 14 days before an elective pre-certifiable service is rendered. The Plan also requires notification within 48 hours of an admission, or as soon as reasonably possible.

Failure to Precertify required services will result in a benefit penalty of 50% of the Plan's Allowable Charges to a maximum of $10,000. Any penalty due to failure to follow Medical Precertification procedures will not accrue toward the 100% Maximum Out-of-Pocket payment. Refer to the Schedule of Benefits for details on Medical Precertification penalties.

In-Network: Your Physician is responsible for obtaining any necessary Medical Precertification before You get the care. If Your Physician doesn't get a required Medical Precertification, the Provider who gives You the care will not be paid. You won't have to pay either if Your Physician fails to obtain a Medical Precertification. If Your Physician requests Medical Precertification and it is not approved, You can still get the care, but the Plan won't pay for it.

Out-of-Network: When You go to an Out-of-Network Provider, it is Your responsibility to obtain Medical Precertification from the Plan for any services and supplies on the Medical Precertification list. If You do not precertify, Your benefits may be reduced. Refer to Your schedule of benefits for this information. You can access the full list of services that require Medical Precertification on the Plan's website at www.membershealthplannj.com or You can contact the Plan to request a hard copy at any time.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, Medical Precertification should be secured within the timeframes specified below. To obtain Medical Precertification, call Us at the telephone number listed on Your ID card.

For non-emergency admissions:	You, Your Physician or the Facility will need to call and request Medical Precertification at least 14 days before the date You are scheduled to be admitted.
For an emergency admission:	You, Your Physician or the Facility must call within 48 hours or as soon as reasonably possible after You have been admitted.
For an urgent admission:	You, Your Physician or the Facility will need to call before You are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
For outpatient non-emergency and non urgent medical services requiring Medical Precertification:	You or Your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

You and Your Physician will be provided written notification of the Medical Precertification decision, where required by state law. If Your Precertified services are approved, the approval is valid for 60 days as long as You remain enrolled in the Plan.

When You have an inpatient admission to a Facility, You, Your Physician and the Facility will be notified about Your Precertified length of stay. If Your Physician recommends that Your stay be extended, additional days will need to be Precertified. You, Your Physician, or the Facility will need to call us at the number on Your ID card as soon as reasonably possible, but no later than the final authorized day. The request for an extended stay will be reviewed and processed. You and Your Physician will receive a notification of an approval or denial.

If Medical Precertification determines that the stay or services and supplies are not covered benefits, the notification will explain why and how the decision can be appealed. You or Your Provider may request a review of the Medical Precertification decision. See the *Claim decisions and appeals procedures* section.

What if You don't obtain the required Medical Precertification?

If You don't obtain the required Medical Precertification:

1) Your benefits may be reduced.
2) You will be responsible for the unpaid balance of the bills.
3) Any additional out-of-pocket expenses incurred will not count toward Your Out-of-Network deductibles or Maximum Out-of-Pocket limits.

What types of services require Medical Precertification?

Medical Precertification is required for the following types of services and supplies:

1) Inpatient services and supplies
2) Stays in a Hospital
3) Stays in a Skilled Nursing Facility
4) Stays in a Rehabilitation Facility
5) Stays in a Hospice Unit
6) Stays in a Residential Treatment Facility for treatment of Mental Health Conditions
7) Stays in a Residential Treatment Facility for treatment of Substance Use Disorders. See below for Substance Use Disorders – Network Only requirement
8) Bariatric surgery (obesity)
9) Comprehensive infertility services
10) Cosmetic and reconstructive surgery

Precertification cannot be required for Pregnancy confinements less than 48/96 hours for natural/cesarean section.

Certain prescription drugs are covered under the medical plan when they are given to You by Your doctor or health care Facility and not obtained at a pharmacy. The following Medical Precertification information applies to these prescription drugs:

1) For certain drugs, Your Provider or Your pharmacist needs to get approval from us before we will agree to cover the drug for You. Sometimes the requirement for getting appr
2) oval in advance helps guide appropriate use of certain drugs and makes sure the Drug is Medically Necessary and Appropriate. For the most up-to-date information, call the phone number on Your ID.

You can access the full list of services that require Medical Precertification on the Plan's website at www.membershealthplannj.com or You can contact the Plan to request a hard copy at any time.

CONCURRENT REVIEW, DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Medical Management Review program. The Medical Management Review Administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary and Appropriate for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been Precertified, the attending Physician must request the additional services or days.

PRE-ADMISSION TESTING SERVICE

Refer to the Schedule of Benefits for the Medical Benefits percentage payable for diagnostic lab tests and x-ray exams provided by a Provider when:

1) performed on an outpatient basis within seven days before a Hospital confinement;
2) related to the Condition which causes the confinement; and
3) performed in place of tests while Hospital confined.

The Plan will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Pre-admission testing as set forth above will be reimbursed according to the Schedule of Benefits**.**

ADMISSIONS FOR THE TREATMENT OF SUBSTANCE USE DISORDERS-NETWORK ONLY

This section applies during the first 180 days of In-Network treatment per Plan Year whether the treatment is Inpatient or outpatient. Thereafter, Inpatient treatment of Substance Use Disorders is subject to the above provisions governing Hospital and other Facility admissions.

If a Covered Person is admitted to a Facility for the treatment of Substance Use Disorders, whether for a scheduled admission or for an Emergency admission, the Facility must notify the Plan of the admission and initial treatment plan within 48 hours of the admission.

The Plan will not initiate continued stay review, also known as concurrent review, with respect to the first 28 days of the Inpatient stay. Continued stay review may be required for any subsequent days, but not more frequently than at two-week intervals. If the Plan determines continued stay is no longer Medically Necessary and Appropriate, the Plan shall provide written notice within 24 hours to the Covered Person and his or her Provider along with information regarding appeal rights.

CASE MANAGEMENT

When a catastrophic Condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps Lifetime care. After the person's Condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary and Appropriate care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1) personal support to the patient;
2) contacting the family to offer assistance and support;
3) monitoring Your care while in a Hospital or Skilled Nursing Facility;
4) determining alternative care options; and
5) assisting in obtaining any necessary equipment and services.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment Plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

CLAIMS DECISION AND APPEAL PROCEDURES

CLAIM PROCEDURES

When a claim comes in, You will receive a decision on how You and the Plan will split the expense. This section will also explain what You can do if You think the Plan processed Your claim wrong.

You must provide proof of a claim when You seek services from an Out-of-Network Provider and it must be furnished to the medical Claims Administrator within 90 days following the date services were provided. However, Your claim still will be considered if it was not possible to furnish proof within that time and the proof was furnished as soon as reasonably possible, however, no later than 180 days from the original date services were provided. Claims submitted after the 180th day following the date of service will not be considered eligible for coverage under this Plan and will be the responsibility of the Covered Person.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim. Benefits will be payable to the Covered Person unless benefits have been assigned.

No action at law or in equity may be brought against the Plan prior to the expiration of 180 days after proof of loss has been furnished, nor shall such action be brought within one year from the expiration of the time within which proof of loss is required to be furnished.

The Plan shall have the right to examine any person whose loss is the basis for the claim as often as it may reasonably require, and to perform an autopsy where not forbidden by law. The Plan is not in lieu of and does not affect any requirements for workers' compensation insurance.

ASSIGNING HEALTH CARE BENEFITS

The Plan generally makes payments directly to In-Network Providers or Facilities that provide Your covered services. By using In-Network services, You are automatically authorizing the Plan, and any In-Network Providers or Facilities to release Your relevant medical records to the Medical Management Review Administrator and/or medical Claims Administrator to determine applicable benefits or reimbursements for the services You receive.

The medical Claims Administrator may, at its option, make payment to You for the cost of any covered services received by You or Your covered Dependent Out-of-Network, even if benefits have been assigned. When benefits are paid to You, You are responsible for reimbursing the Provider or Facility. If the person to receive the payment is a minor or, in the medical Claims Administrator's opinion, cannot give a valid receipt for the payment, the Plan will pay that person's legal guardian. If no legal guardian requests payment, the Plan may, at its option pay the person or institution that appears to have responsibility for the person's custody and support.

If You die while any Plan benefits remain unpaid, the Plan may pay any of Your following living relatives: spouse or partner, mother, father, Child or Children, brothers or sisters; or to the executors or administrators of Your estate. The Plan will not be liable for any additional payments to the extent it makes a payment to a living relative or other person listed above.

You cannot assign Your right to receive payment to anyone else without written consent of the Plan, except as may be required by a qualified medical Child support order (QMCSO) or any applicable state law. Once a Provider performs a covered service, the medical Claims Administrator will not honor a request to withhold payment of the claims submitted. Covered Persons may assign direct payments to the providers.

SUBMITTING CLAIMS

In Network Providers will submit claims on Your behalf, however for claims involving Out-of-Network Providers, You must provide a claim for benefits as follows:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from Your Employer. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of Your request. • If the claim form is not sent on time, We will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of Your loss.
Proof of loss	• A completed claim form and any additional	• No later than 90 days after You have incurred expenses

(claim)	information required by Your Employer.	for **covered benefits.** • The Plan void or reduce Your claim if You can't send notice and proof of loss within the required time. But You must send notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if You are legally unable to notify the Plan.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by the Plan, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

TYPES OF CLAIMS AND COMMUNICATING OUR CLAIM DECISIONS

You or Your Provider are required to send a claim in writing. You can request a claim form from the Plan and the Plan will review that claim for payment to the Provider.

There are different types of claims. The amount of time that the Plan has to tell You about the decision on a claim depends on the type of claim. The section below will tell You about the different types of claims.

Urgent care claim

An urgent claim is one for which delay in getting medical care could put Your life or health at risk, or a delay might put Your ability to regain maximum function at risk. Or it could be a situation in which You need care to avoid severe pain.

If You are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of Your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services You have not yet received and which the Plan will pay for only if We precertify them.

Post-service claim

A post service claim is a claim that involves health care services You have already received.

Concurrent care claim extension

A concurrent care claim extension occurs when You ask the Plan to approve more services than the Plan already has approved. Examples are extending a Hospital stay or adding a number of visits to a Provider.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when We decide to reduce or stop payment for an already approved course of treatment. We will notify You of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until You receive a final appeal decision from Us or an Independent Review Organization if the situation is eligible for external review. During this continuation period, You are still responsible for Your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If We uphold our decision at the final internal appeal, You will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time We have to tell You about Our decision.

The Plan may need to tell Your Provider about our decision on some types of claims, such as a concurrent care claim, or a claim when You are already receiving the health care services or are in the Hospital.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request

Extensions	None	15 days	15 days	Not applicable
Additional information request	72 hours	15 days	30 days	Not applicable
Response to additional information request	48 hours	45 days	45 days	Not applicable

*The Plan has to receive the request at least 24 hours before the previously approved health care services end.

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third party administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

ADVERSE BENEFIT DETERMINATIONS

The Plan pays many claims at the full rate negotiated charge with a Network Provider and the Plan's Allowable Charge amount with an Out-of-Network Provider, except for Your share of the costs. But sometimes the Plan pays only some of the claim. And sometimes the Plan may deny payment entirely. Any time the Plan may deny even part of the claim that is an "Averse Benefit Determination" or "adverse decision". It is also an "Adverse Benefit Determination" if the Plan rescinds Your coverage entirely.

If the Plan makes an Adverse Benefit Determination, You will be notified in writing.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a Provider or an operational issue, and You may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that You think are important. We will review the information and provide You with a written response within 30 calendar days of receiving the complaint**.** We will let You know if We need more information to make a decision.

An Appeal

You can ask Us to re-review an adverse benefit determination. This is called an appeal. You can appeal to Us verbally or in writing.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

You can appeal our adverse benefit determination. We will assign Your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time You receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or You can call Member Services at the number on the back of Your ID card. You need to include:

- Your name
- The name of the Plan
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information You would like the Plan to consider

Another person may submit an appeal for You, including a Provider. That person is called an authorized representative. You need to tell the Plan if You choose to have someone else appeal for You (even if it is Your Provider). You should fill out an authorized representative form telling the Plan that You are allowing someone to appeal for You. You can get this form by contacting Member Services at the number on the back of Your ID card. You can use an authorized representative at any level of appeal.

You can appeal two times under this Plan. If You appeal a second time You must present Your appeal within 60 calendar days from the date You receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals
If Your claim is an urgent claim or a pre-service claim, Your Provider may appeal for You without having to fill out a form. We will provide You with any new or additional information that We used or that was developed by the Plan to review Your claim. We will provide this information at no cost to You before We give You a decision at Your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before We will tell You what the final decision is.

Timeframes for deciding appeals
The amount of time that We have to tell You about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time We have to tell You about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process
In most situations You must complete the two levels of appeal with the Plan before You can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes You do not have to complete the two levels of appeals process before You may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have Your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, You will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm You.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between You and the Plan.

External review
External review is a review done by people in an organization outside of the medical Claims Administrator. This is called an Independent Review Organization (IRO).

You have a right to external review only if:

- The claim decision involved medical judgment.
- The Plan decided the service or supply is not medically necessary or not appropriate.
- The Plan decided the service or supply is experimental or investigational.
- You have received an Adverse Benefit Determination .

If the claim decision is one for which You can seek external review, the Plan will say that in the notice of adverse benefit determination or final adverse benefit determination sent to You. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final Adverse Benefit Determination level.

You must submit the Request for External Review Form:

- To medical Claims Administrator
- Within 123 calendar days (four months) of the date You received the decision from the Plan
- And You must include a copy of the notice from the Plan and all other important information that supports Your request

You will pay for any information that You send and want reviewed by the ERO. We will pay for information We send to the ERO plus the cost of the review.

Medical Claims Administrator will:

- Contact the ERO that will conduct the review of Your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that You sent.
- Follow our contractual documents and Your plan of benefits.
- Send notification of the decision within 45 calendar days of the date the Plan receives Your request form and all the necessary information.

The Plan will stand by the decision that the ERO makes, unless We can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?
The Plan will tell You of the ERO decision not more than 45 calendar days after the Plan receives Your Notice of External Review Form with all the information You need to send in.

But sometimes You can get a faster external review decision. Your Provider must call the Plan or send in a Request for External Review Form.

There are two scenarios when You may be able to get a faster external review:

For initial Adverse Benefit Determinations
Your Provider tells the Plan that a delay in Your receiving health care services would:
- Jeopardize Your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final Adverse Benefit Determinations
Your **Provider** tells the Plan that a delay in Your receiving health care services would:
- Jeopardize Your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which You received **emergency services**, but have not been discharged from a Facility

If Your situation qualifies for this faster review, You will receive a decision within 72 hours of the Plan getting Your request.

Recordkeeping
The medical Claims Administrator will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses
We do not pay any fees or expenses incurred by You in pursuing a complaint or appeal.

CONTINUATION OF CARE

The Plan shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from the Plan's Provider network of a Covered Person's PCP and any other Provider from which the Covered Person is currently receiving a course of treatment, as reported to the Plan. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a Determination of fraud, or where the Plan's medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

The Plan shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional. In case of Pregnancy of a Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to Pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person who is receiving post-operative follow-up care, the Plan shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a Covered Person who is receiving oncological treatment or psychiatric treatment, the Plan shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Covered Person receiving the above services in an acute care Facility, the Plan will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with the Plan.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with the Plan. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with the Plan.

If a Covered Person is admitted to a health care Facility on the date the Plan is terminated as to such person, the Plan shall continue to provide benefits for the Covered Person until the date the Covered Person is discharged from the Facility or exhaustion of the Covered Person's benefits under the Plan, whichever occurs first.

The Plan shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of the Plan's medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a Determination of fraud or a breach of contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in the Plan. The Plan shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with the Plan.

If the Plan refers a Covered Person to a Out-of-Network Provider, the service or supply shall be covered as an In-Network service or supply. The Plan is fully responsible for payment to the health care professional and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.

COORDINATION OF BENEFITS

If You Are Covered by More Than One Medical Plan
A Covered Person may be covered for health benefits or services by more than one Plan. For instance, a Covered Person may be covered by the Plan as an Employee and by another Plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows the Plan to coordinate what the Plan pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

DEFINITIONS
The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When the Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, Prescription Drugs or hearing aids, Allowable Expense is limited to like items of expense.

The Plan will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When the Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Plan will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by the Plan and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

1) Group insurance and group Subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
2) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
3) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
4) Group Hospital indemnity benefit amounts that exceed $150 per day;
5) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or non-governmental plan.

Plan does not include:

1) Individual or family insurance contracts or Subscriber contracts;
2) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
3) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a plan;
4) Group Hospital indemnity benefit amounts of $150 per day or less;
5) School accident –type coverage;
6) A State Plan under Medicaid.

Primary Plan: A Plan whose benefits for a Covered Person's health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

a) The Plan has no order of benefit Determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
b) All plans which cover the Covered Person use order of benefit Determination rules consistent with those contained in this Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by **the Plan**, based on a standard which is most often charged for a given service by a Provider of services within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a Covered Person is covered by more than one Secondary Plan, the order of benefit Determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

The Plan considers each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit Determination rules differ from those set forth in these provisions, it is the primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the secondary Plan. If there is more than one secondary Plan, the order of benefit Determination rules determine the order among the secondary Plans. During each Claim Determination Period the secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and Appropriate services or supplies on the basis that Medical Precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Covered Person as an Employee, member, Subscriber or retiree shall be determined before those of the Plan that covers the Covered Person as a Dependent. The coverage as an Employee, member, Subscriber or retiree is the primary Plan.

The benefits of the Plan that covers the Covered Person as an Employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Covered Person as a laid off or retired Employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit Determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Covered Person as an Employee, member, Subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers Covered Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit Determination, this portion of this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

1) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
2) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of Plan which covered the other parent for a shorter period of time.
3) Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.
4) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

1) The benefits of the Plan of the parent with custody of the Child shall be determined first.
2) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
3) The benefits of the Plan of the parent without custody shall be determined last.

4) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the primary Plan, the benefits of the Plan that covers the Employee, member or Subscriber for a longer period of time shall be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

1) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
2) whether the Provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary charge is called an "R&C Plan."

Benefits may be based on a contractual Fee Schedule, sometimes called a negotiated Fee Schedule, or some similar term. This means that although a Provider, called a Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated Fee Schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of a Out-of-Network Provider, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a Fee Schedule.

Payment to the Provider may be based on a "capitation". This means that the HMO or other Plans pays the Provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable Deductible, Coinsurance or Copayment. If the Covered Person uses the services of an Out-of-Network Provider, the HMO or other Plans will only pay benefits in the event of Emergency care or Urgent Care. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

In the rules below, "Provider" refers to the Provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Provider is a Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the Fee Schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1) the amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the Fee Schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance or Deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the Provider is a Network Provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

1) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Covered Person shall only be liable for the Copayment, Deductible or Coinsurance under the Secondary Plan if the Covered Person has no liability for Copayment, Deductible or Coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the Provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the Provider is a Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the Fee Schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1) the amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or

2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or Emergency care and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or Emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

1) the amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

If You need medical or dental care as a result of an Automobile Related Injury, the Plan provides either primary or secondary coverage to "personal Injury protection coverage" (PIP) provided as part of an automobile insurance policy issued in New Jersey. You choose which Plan You want to be primary when You sign up for automobile insurance.

The option to designate this Plan as primary applies to the named insured and resident relatives who are not themselves the named insureds under another automobile insurance policy and are formally covered by this Plan. The option does not apply to any guest, passenger, or pedestrian unless they are the named insured or resident relative of the insured. Upon renewal or purchase of a New Jersey auto insurance policy, the auto insurance carrier will provide a Coverage Selection Form for the insured to designate their choice for their primary payer on auto related medical expenses.

The Plan is a secondary payer to "out-of-state automobile insurance coverage" (OSAIC), unless You choose otherwise, or OSAIC or a law of the state in which the OSAIC is issued contains provisions which would require this Plan to pay its benefits before OSAIC does.

If there is a dispute as to which Plan is primary, the Plan will pay benefits for eligible expenses as if it were primary.

When this Plan is selected as the primary payer, the liability for these services will be covered to the same extent as any other service and subject to all of the applicable contract provisions and limitations. The automobile insurer providing PIP medical expense coverage will be liable for reasonable medical expenses not covered by the health plan, up to the limit of the insured's PIP medical expense benefit coverage.

When this Plan is selected as the secondary payer, this Plan will be liable for the Deductible, Coinsurance and eligible expenses not covered by PIP within the cap chosen by the insured and eligible expenses above the PIP cap to the same extent as any other service and subject to all of the applicable contract provisions and limitations.

The coordination of benefits provision of the Plan will apply in the following circumstances:

1) You are covered under more than one Plan; and
2) the Plan is primary to automobile insurance coverage.

COORDINATION WITH MEDICARE- MEDICARE AS SECONDARY PAYOR

This Plan is treated as a large Employer Plan for purposes of "Medicare as Secondary Payor" rules. Regardless of whether Your Employer has between 2-19 Employees and would not normally be subject to "Medicare as Secondary Payor" rules, this "Medicare as Secondary Payor" rule will apply to all enrolled Covered Persons of the Plan.

The following provisions explain how the Plan's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

1) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVI of the United States Social Security Act, as amended from time to time.
2) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is

considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

3) A "primary" health Plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" Plan pays. A "secondary" health Plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section above for a definition of "Allowable Expense".

MEDICARE ELIGIBILITY BY REASON OF AGE
(Applies to all enrolled Covered Persons of the Trust)

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
1) a Covered Person, other than an Employee or insured spouse
2) an Employee or insured spouse who is under age 65, or
3) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.
4) a covered Civil Union partner or a covered Domestic Partner who is eligible for Medicare by reason of age.

When A Covered Person or Covered Spouse Becomes Eligible For Medicare
When a Covered Person or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Plan as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Plan is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Plan will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, the Plan will pay benefits as if he or she had chosen Option (A).

When the Plan is Primary
When a Medicare eligible chooses the Plan as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Plan and Medicare, the Plan is considered primary. The Plan pays first, ignoring Medicare. Medicare is considered the Secondary Plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Plan. Coverage under the Plan will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Plan as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY
Applicability
This section applies to a Covered Person who is:
1) under age 65 and
2) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible". This section does not apply to:
1) a Covered Person who is eligible for Medicare by reason of age; or
2) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.
3) Covered Person who is the Employee's Civil Union partner or Domestic Partner or the Child of the Employee's Civil Union partner or Domestic Partner.

When A Covered Person Becomes Eligible for Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Plan is the Primary Plan. Medicare is the Secondary Plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B of Medicare. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Plan.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD). Under this section such Covered Person is referred to as an "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Plan and Medicare, the Plan is considered primary. The Plan pays first, ignoring Medicare. Medicare is considered the Secondary Plan.

This 30-month period begins on the earlier of:

1) the first day of the month during which a regular course of renal dialysis starts; and
2) with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30-month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Plan and Medicare, Medicare is the Primary Plan. The Plan is the Secondary Plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B of Medicare. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Plan.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a Dependent Child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. "You" or "Your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor Child or Children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all coverage available to You due to an injury, illness or Condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or Condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or Condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or Condition, up to and including the full amount of Your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an injury, illness or Condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or Condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or Condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or Condition. You and Your agents agree to provide the Plan, or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the medical Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or Condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified You that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share Your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the medical Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

CONTINUING COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) RIGHTS

The Plan Administrator is the Trust. The Continuation Plan Administrator is Office of Compliant Administration (OCA). OCA is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Plan Administrator to Covered Persons who become Qualified Continuees under COBRA.

The following section applies to Employer groups that have elected OCA as the Continuation Plan Administrator regardless of how many employees the Employer has. You must contact Your Employer to find out who has been selected as the Continuation Plan Administrator in order to determine which continuation benefits apply. (Refer to NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR) section for continuation options for Groups with fewer than 20 employees that not selected the Plan's Continuation Plan Administrator, OCA.)

What is COBRA continuation coverage?
COBRA continuation coverage is the temporary extension of Group Health Plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Continuees") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Continuee had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "Qualifying Event". COBRA usually applies to Employers with 20 or more Employees, however, this Plan provides Employers with less than 20 Employees the same coverage as COBRA, if they have selected the Plan's Continuation Plan Administrator, OCA.

Who can become a Qualified Continuee?
In general, a Qualified Continuee can be:

1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee.
2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order.

What is a Qualifying Event?
Qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued is as follows:

Qualifying Event causing loss of coverage	**Covered persons eligible for continued coverage**	**Length of continued coverage (starts from the day You lose current coverage)**
Your active employment ends for reasons other than gross misconduct	You and Your dependents	18 months
Your working hours are reduced	You and Your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent Children no longer qualify as dependent under the Plan	Your dependent Children	36 months
You die	Your dependents	36 months

When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/Group health Plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – Employer or **OCA**	Notify You and Your dependents of COBRA rights.	Within 90 days after active Employee coverage begins
Notice of Qualifying Event – Employer	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and Your former Employer files for bankruptcy	Within 30 days of the Qualifying Event or the loss of coverage, whichever occurs later
Election notice – Employer or **OCA**	Notify You and Your dependents of COBRA rights when there is a Qualifying Event	Within 14 days after notice of the Qualifying Event
Notice of unavailability of COBRA **–** Employer **or OCA**	Notify You and Your dependents if You are not entitled to COBRA coverage.	Within 14 days after notice of the Qualifying Event
Termination notice **–** Employer or **OCA**	Notify You and Your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/Your dependents notification requirements		
Notice of Qualifying Event – qualified beneficiary	Notify Your Employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent Children no longer qualify as a dependent under the Plan	Within 60 days of the Qualifying Event or the loss of coverage, whichever occurs later
Disability notice	Notify Your Employer if: • The Social Security Administration determines that You or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18-month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify Your Employer if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify Your Employer if: • You are electing COBRA	60 days from the Qualifying Event. You will lose Your right to elect, if You do not: • Respond within the 60 days; and • send back Your application

How can You extend the length of Your COBRA coverage?
The chart below shows Qualifying Events after the start of COBRA (second Qualifying Events):

Qualifying Event	**Person affected (qualifying beneficiary)**	**Total length of continued Coverage**
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security	You and Your dependents	29 months (18 months plus an additional 11 months)

Administration)		
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent Children no longer qualify as dependent under the Plan	You and Your dependents	Up to 36 months

Can You add a dependent to Your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the Employer within 31 days of their eligibility.
- You pay the additional required Healthcare Fees.

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The Plan ends. If the Plan is replaced, You may be continued under the new Plan.
- You and Your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health Plan that does not exclude coverage for pre-existing Conditions or the pre-existing Conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or Your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Is a Covered Person or Qualified Continuee responsible for informing their Employer of the occurrence of a Qualifying Event?
Yes. The Plan will offer COBRA continuation coverage to Qualified Continuees only after the Plan has been timely notified that a Qualifying Event has occurred. The Participating Employer will notify the Plan of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1) the end of employment or reduction of hours of employment;
2) death of the Covered Person;
3) commencement of a proceeding in bankruptcy with respect to the Participating Employer; or
4) enrollment of the Covered Person in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You or someone on Your behalf must notify The Plan <u>in writing</u> within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided <u>in writing</u> to the Plan during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan.

<u>WHEN TO CONTACT THE PLAN</u>
NOTICE OF PROCEDURES FOR NOTIFYING THE PLAN OF TERMINATION OF EMPLOYMENT:
Any notice that You provide must be ***<u>in writing</u>***. Verbal notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver the notice to:

Members Health Plan NJ
399 Campus Drive, 3rd Floor, Suite #300
Somerset, NJ 08873
Fax: 833-MEWAFAX (833-639-2329)

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state:

1) ***The name of the plan or plans*** under which You lost or are losing coverage,
2) The ***name and address of the Covered Person*** under the plan,

3) The ***name(s) and address(es) of the Qualified Continuee(s)***, and
4) The ***Qualifying Event*** and the ***date*** it happened.

Once the Plan receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Continuees. Each Qualified Continuee will have an independent right to elect COBRA continuation coverage. Covered Persons may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Continuee who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If You or Your spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

WHEN TO CONTACT OCA (COBRA ADMINISTRATOR)
Once a Qualified Continuee receive a COBRA Election letter, elects or enrolls in COBRA, they should contact OCA directly for COBRA questions. OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, phone: (609) 514- 0777, fax: (609) 514-2778.

Is a waiver before the end of the election period effective to end a Qualified Continuee's election rights?
If, during the election period, a Qualified Continuee waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to OCA, as applicable.

How much will COBRA coverage cost?
For most COBRA Qualifying Events You and Your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If You apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either 1) under the terms of the Plan, Covered Persons or Qualified Continuees are allowed until that later date to pay for their coverage for the period or 2) under the terms of an arrangement between the Participating Employer and the entity that provides Plan benefits on the Participating Employer's behalf, the Participating Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Continuee earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Continuee. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Continuee of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Continuee be given the right to enroll in a conversion health Plan at the end of the maximum coverage period for COBRA continuation coverage?
The Plan does not offer a conversion option therefore, a conversion option is not available to Qualified Continuees.

IF YOU HAVE QUESTIONS
If You have questions about Your COBRA continuation coverage, You should contact OCA **or Your Employer** or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR EMPLOYER AND/OR THE PLAN INFORMED OF ADDRESS CHANGES
In order to protect Your family's rights, You should keep the Plan and Your Employer informed of any changes in the

addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan or Your Employer.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

The following section applies to Employer groups with fewer than 20 employees that have selected an independent Continuation Plan Administrator and are not utilizing the Plan's Continuation Administrator, OCA. The Employee must contact his or her Employer to find out who has been selected as the Continuation Plan Administrator in order to determine which continuation benefits apply.

New Jersey has a continuation requirement similar to COBRA, but one that's applicable to Small Employers, i.e., those having 2 to 50 Employees (including Part-Time Employees) **N.J.S.A. 17B:27A-27 (as amended by P.L.2004, c.162)**. Employers have a legal obligation to notify their Employees of the right to continue coverage at the time of termination or at the time the Employee assumes part-time status. Employers are not required to contribute to the Health Care Fees. Every Small Employer in New Jersey offering coverage to its Employees shall offer continued coverage under the Plan to any Employee who experiences a Qualifying Event, as defined below.

Qualifying Events that trigger NJGCR continuation, which is eligible for continuation and how long coverage can be continued.

Qualifying Event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day You lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and Your dependents	18 months
Your working hours are reduced	You and Your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent Children no longer qualify as dependent under the Plan	Your dependent Children	36 months
You die	Your dependents	36 months

The chart below shows Qualifying Events after the start of NJGCR (second Qualifying Events):

Qualifying Event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and Your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce or legally separate and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent Children no longer qualify as dependent under the Plan	You and Your dependents	Up to 36 months

How do I elect Continuation Coverage?

You should contact the Continuation Plan Administrator selected by Your Employer.

Does the Plan require payment for Continuation Coverage?

The Plan requires payment of contributions by the Employee, spouse or Dependent Child for any period of continuation

coverage as provided for in this section, except that the contribution shall not exceed 102%, or 150% in the case of continuation of coverage for disability, of the applicable contribution (both the Employer- and Employee-paid amounts) paid for similarly situated beneficiaries under the Plan. Payment may, at the election of the payor, be made in monthly installments. No payment shall be due before the 30th day after the day on which the Covered Person made the initial election for continued coverage.

If You fail to give Your Employer notice that You elect to continue or fail to make any Health Care Fees payment in a timely manner, You waive Your continuation rights. All payments will be considered timely if they are made within 31 days of the specified due dates.

Who can become a Qualified Continuee?
In general, a Qualified Continuee can be:

1) any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day a Covered Person;
2) any spouse who is a Qualified Continuee under the Plan by reason of being the spouse of a Covered Person on the day before the Qualifying Event;
3) to any Dependent Child who is a Qualified Continuee under the Plan by reason of being the Dependent Child of a Covered Person on the day before the Qualifying Event, subject to the applicable terms of the Plan; and
4) to any such spouse or Dependent Child who is a Qualified Continuee under the Plan whenever that spouse or Dependent Child is no longer entitled to coverage under the Plan by reason of the death of the Covered Person or the divorce of the Covered Person from the spouse.

What Benefits Can Be Continued?
Coverage can be continued which is identical to the coverage provided under the Plan to similarly situated Qualified Continuees. If coverage is modified under the Plan for any group of similarly situated Qualified Continuees, this continuation coverage shall also be modified in the same manner for persons who are Qualified Continuees. Continuation of coverage may not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

What are the maximum coverage periods for continuation coverage?
The maximum time coverage can be continued is 18 months.

Under what circumstances can the maximum coverage period be expanded?
Continuation of coverage provided for under this section shall not exceed 18 months from the Qualifying Event, except that:

1) In the case of a spouse or Dependent Child who is a Qualified Continuee, continuation of coverage shall extend until the date 36 months after the date the spouse's or Dependent Child's benefits under the Plan would otherwise have terminated by reason of the death of the Employee, the divorce of the Employee from the spouse or a Dependent Child ceasing to be a Dependent Child under the applicable provisions of the Plan; and
2) In the case of an Employee who is determined to have been disabled under Title II or XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) at the time of termination of employment or at any time during the first 60 days of continuation of coverage, continuation of coverage shall extend until 29 months after the date benefits under the Plan would have terminated; provided, however, that if the Employee is no longer disabled, continuation of coverage shall terminate on the later date of 18 months or the month that begins more than 31 days after the date of final Determination under Title II or Title XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) that the Employee is no longer disabled. The Employee shall provide notification of the disability Determination under Title II or XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) to the Plan within 60 days of the date of that Determination, and within 18 months of the date benefits under the Plan would have terminated.

When may a Qualified Continuee's continuation coverage be terminated?
Coverage continued pursuant to this section shall continue until the earliest of the following:

1) month period which starts on the date the group health benefits would otherwise end;
2) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 -month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
    a) the end of the 18-month period; or the first day of the month that begins more than 31 days after the date on which a final Determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
3) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the Civil Union, or termination of the Domestic Partnership or the end of a covered Dependent's eligibility, the end of the 36- month period which starts on the date the group health benefits would otherwise end;

4) The date upon which the Employer under whose Health Benefits Plan coverage is continued ceases to provide any Health Benefits Plan to any Employee or other Qualified Continuee;
5) The date on which the continued coverage ceases under the Plan by reason of a failure to make timely payment of any contribution required under the Plan by the former Employee, spouse, or Dependent Child having the continued coverage. The payment of any contribution shall be considered to be timely if made within 30 days after the due date or within such longer period as may be provided for by the Plan; or
6) The date after the date of election on which the Qualified Continuee first becomes:
   a) Covered under any other Health Benefits Plan, as an Employee or otherwise, which does not contain a provision which limits or excludes coverage of a Covered Person or any spouse or Dependent Child who is included under the coverage provided the Covered Person, for such period of the limitation or exclusion; or
   b) Entitled to Medicare after electing continued coverage.

RIGHTS FOR OVER-AGE DEPENDENTS

Over-Age Dependent is an Employee's Child by blood or law who:

1) has reached the limiting age under the group Plan, but is less than 31 years of age;
2) is not married or in a Domestic Partnership or Civil Union partnership;
3) has no Dependents of his or her own;
4) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
5) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage

If a Dependent Child is over the age 26 limiting age for Dependent coverage, and:

1) the Dependent Child's group health benefits are ending or have ended due to his or her attainment of age 26; or
2) the Dependent Child has proof of prior creditable coverage or receipt of benefits, he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the conditions for Election, Election of Continuation and When Continuation Ends sections below.

Election of Continuation

To maintain continuous group health benefits, the Over-Age Dependent must make written election to The Plan within 30 days of the date the Over-Age Dependent attains age 26. The Effective Date of the continued coverage will be the date the Dependent would otherwise lose coverage due to attainment of age 26 provided written notice of the election of coverage is given and the first Health Care Fees is paid.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made within 30 days of the date the Over-Age Dependent attains age 26. The Effective Date of coverage will be the date the Dependent attains age 26 provided written notice of the election of coverage is given and the first Health Care Fees is paid within such 30-day period.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made within 30 days of the date the person meets all of the requirements for an Over-Age Dependent.

If the election is not made within the 30-day periods described above an eligible Over-Age Dependent may subsequently enroll during an Employee Open Enrollment Period.

Payment of Health Care Fees

The first month's Health Care Fees must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period, the first Health Care Fees must be paid before coverage takes effect on the Employer's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent Health Care Fees monthly, in advance, at the times and in the manner specified by the COBRA Administrator and will be remitted by the Employee.

Grace in Payment for An Over-Age Dependent's Health Care Fees payment is timely if, with respect to all payments other than the first payment, such Health Care Fees payment is made within 30 days of the date it is due.

The Continued Coverage

The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an

Employee under the Plan and will be evidenced by a separate ID card being issued to the Over-Age Dependent. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner.

When Continuation Ends

An Over-Age Dependent's continued group health benefits end on the first of the following:

1) The date the Over-Age Dependent:
   a) attains age 31;
   b) marries or enters into a Civil Union partnership;
   c) acquires a Dependent;
   d) is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   e) becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.
2) The end of the period for which Health Care Fees has been paid for the Over-Age Dependent, subject to the Grace Period for such payment.
3) The date the Plan ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Plan.
4) The date the Plan under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
5) The date the Over-Age Dependent's parent who is covered as an Employee under the Plan waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Plan for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's Healthcare Fee. This must be done within 31 days of the date his or her coverage under this Plan would otherwise end. Subsequent Healthcare Fees must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly Healthcare Fee the Employee must pay will be the total rate charged for an active Full- Time Employee, covered under this Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

The Plan will consider the Employee's failure to give notice or to pay any required Healthcare Fee as a waiver of the Employee's
continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay the Plan on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, the Plan.

In the event the Employer replaces the group health benefits with another such plan, the Disabled Employee has the right to become covered under the replacement group health benefits plan.

When This Continuation Ends

These continued group health benefits end on the first of the following:

1) the end of the period for which the last payment is made, if the Employee stops paying;
2) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be a covered or not covered plan;
3) the date this Plan ends or is amended to end for the class of Employees to which the Employee belonged; or
4) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Plan.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE
This section may not apply to an Employer's Plan. The Employee must contact his or her Employer to find out if:
The Employer must allow for a leave of absence under Federal law in which case the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a Child. If so, his or her group health benefits coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of Healthcare Fees as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
1) the date the Employee returns to Full-Time work;
2) the end of a total leave period of 12 weeks in any 12-month period;
3) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
4) the end of the period for which the Healthcare Fee has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
If an Employee dies, any of his or her Dependents who were covered under this Plan may elect to continue coverage. Subject to the payment of the required Healthcare Fees, coverage may be continued until the earlier of:
1) 180 days following the date of the Employee's death; or
2) the date the Dependent is no longer eligible under the terms of this Plan.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN SPONSOR. The Plan is sponsored by the Trust.

PLAN ADMINISTRATOR. The Plan Administrator is the Trust and its Trustees. The day-to-day operation of the Plan is managed by Concord Management Resources as its authorized delegate. However, the Trust has sole and final Discretion and authority to determine eligibility for benefits, and to interpret provisions of the Plan. The Plan Administrator may allocate or delegate certain functions as it deems appropriate. Benefits under the Plan will be paid only if the Plan Administrator (or its authorized delegate) decides in its Discretion that under the terms of the Plan the applicant is entitled to the benefit. The decisions of the Plan Administrator or its delegate are final and binding.

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

DUTIES AND AUTHORITY OF THE PLAN ADMINISTRATOR.

1) To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.
2) To make decisions and Determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.
3) To determine the rights, eligibility, and benefits of Covered Persons and beneficiaries under the Plan, including deciding disputes which may arise relative to a Covered Person's rights. Benefits under this Plan will be paid only if the Plan Administrator, or its designee or delegate decides in its Discretion that the applicant is entitled to them.
4) To describe procedures for filing a claim for benefits and to review claim denials.
5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
6) To appoint a medical Claims Administrator to pay claims.
7) To perform all necessary reporting as required by ERISA.
8) To establish and communicate procedures to determine whether a medical Child support order is qualified under ERISA Sec. 609.
9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan Sponsor.

FIDUCIARY. A fiduciary exercises Discretionary authority or control over management of the Plan or the disposition of its assets, has Discretionary authority or responsibility in the administration of the Plan.

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

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

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan's governing document(s). If such document(s) does not indicate the named fiduciary(ies), the Plan Sponsor shall be the named fiduciary. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a Trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

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

MEDICAL CLAIMS ADMINISTRATOR. The Plan Administrator has delegated claim fiduciary duties to Aetna and therefore Aetna shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B) and shall pay claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN FUNDING AND PAYMENT OF BENEFITS. The Plan does not have a dedicated source of funding. The funding for the

benefits is derived from the healthcare fees charged to each Participating Employer and any contributions, if any, made by Covered Persons. The Plan is not insured. The level of any Covered Person contributions will be set by each Participating Employer. Benefits are generally paid through the medical Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN. The Trust expects to continue the Plan, but necessarily reserves the right at any time, by or pursuant to action of its authorized officer(s) or other personnel to amend or terminate the Plan in any and all respects including without limitation, the right to amend the Plan to reduce, change, eliminate and/or modify the type or amount of coverage or benefits provided to any class of Covered Persons receiving or entitled to receive benefits, including the cost of benefits to such individual, without prior notice to such individuals. Upon termination of the Plan, all elections relating to the Plan will terminate, and reimbursements and payments with respect to Plan benefits will be made only with respect to Claims for expenses incurred on or prior to the date of the Plan's termination.

Any amendments to this Plan will be in writing.

ERISA RIGHTS

YOUR RIGHTS UNDER ERISA

As a Covered Person in the Plan described in this booklet, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and collective bargaining agreements, 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.
3) 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.
4) Continued health care ("COBRA") coverage for Yourself, Your 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 coverage rights.
5) You will be provided, only upon request, with a certificate of Creditable Coverage, free of charge, from Your Group Health Plan or health insurance issuer 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.

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Covered Persons and beneficiaries. No one, including Your Employer, Your union, if any, 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.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $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 a 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 or a medical Child support order, 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 should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

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, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or:

The Division of Technical Assistance and Inquiries Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, N.W. Washington, DC 20210

Upon written request Covered Persons may receive from the Plan Administrator as to whether a particular Employer or Employer organization is a sponsor of the Plan and if the Employer or Employee organization is a Plan Sponsor, the sponsor's address.

The name, title and address and the principal place of business of each Trustee of the Plan are available upon written request.

FUTURE OF THE PLAN

While the Trust expects to continue the Plan as outlined in this booklet, the Trust reserves the right to terminate, modify or

amend it at any time without notice. Any claims submitted after the Effective Date of termination, modification or amendment are payable in accordance with the revised Summary Plan Description. In the event that the Plan terminates, You will be informed of any termination rights You may have.

PLAN ADMINISTRATION INFORMATION

The Plan is a self-funded health Plan and the administration is provided through medical and prescription third party and Claims Administrators. The funding for the benefits is derived from the Health Care Fees charged to each Participating Employer and any contributions, if any, made by Covered Persons. The Plan is not insured.

NAME OF PLAN	Members Health Plan NJ
PLAN SPONSOR	Affiliated Physicians and Employers Master Trust
PLAN ADMINISTRATOR	Affiliated Physicians and Employers Master Trust 833-MEWANOW (833-639-2669) P.O. Box 5487, Somerset, NJ 08875
EMPLOYER IDENTIFICATION NUMBER (EIN)	45-6416517
PLAN NUMBER	501
CLASSIFICATION AND FUNDING	The Plan described in this SPD is classified as a welfare benefits plan by the Department of Labor. It is funded by both the Employer and Employee.
TYPE OF ADMINISTRATION	Contract Administration. Benefits are provided in accordance with the provisions of the Plan Sponsor.
NAMED FIDUCIARY	Board of Trustees and Aetna Life Insurance Company.
AGENT FOR SERVICE OF LEGAL PROCESS	Megna Law Firm 24 Arnett Avenue, Suite 115, Lambertville, NJ 08530
MEDICAL BENEFITS	
THIRD PARTY ADMINISTRATOR	Aetna Life Insurance Company 151 Farmington Avenue, RT65, Hartford, CT 06156
CLAIMS ADMINISTRATOR AND CLAIM FIDUCIARY	Aetna Life Insurance Company 151 Farmington Avenue, RT65, Hartford, CT 06156
APPEALS ADMINISTRATION	Aetna Life Insurance Company 151 Farmington Avenue, RT65, Hartford, CT 06156
MEDICAL MANAGEMENT REVIEW ADMINISTRATOR	Aetna Life Insurance Company 151 Farmington Avenue, RT65, Hartford, CT 06156
PRESCRIPTION BENEFITS	
CLAIMS ADMINISTRATOR – PRESCRIPTION	Express Scripts 1 Express Way, St. Louis, MO 63121
PRESCRIPTION MEDICAL MANAGEMENT REVIEW ADMINISTRATOR	Express Scripts 1 Express Way, St. Louis, MO 63121
COBRA BENEFITS	
PLAN ADMINISTRATOR FOR COBRA PURPOSES	Office of Compliant Administration (OCA)
GENERAL	
PLAN ADMINISTATOR AUTHORITY AND POWERS	The Plan Administrator shall have exclusive discretionary authority and power to determine eligibility for benefits and to construe the terms and provisions of this Plan, to determine questions of fact and law arising under this Plan, and to exercise all of the powers necessary for the operation of this Plan.
MEDICAL CLAIMS ADMINISTRATOR AUTHORITY AND POWERS	The Plan Administrator has delegated claim fiduciary duties to Aetna and therefore Aetna shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B). Aetna is responsible for appeal administrative services and final claim determination and the legal defense of disputed benefit payments.

PLAN MODIFICATION AND TERMINATION INFORMATION	Notwithstanding anything to the contrary in SPD, the Plan Sponsor/Administrator expressly reserves the right, at any time, for any reason and without limitation to terminate, modify or otherwise amend this Plan and any or all of the benefits provided there under, either in whole or in part, whether to all persons covered thereby or one or more groups thereof. These rights include specifically, but are not limited to, (1) the right to terminate benefits under the Plan with respect to any Covered Person therein; (2) the right to modify benefits under this Plan to all or any group of Covered Persons therein; (3) the right to require or increase contributions by any Covered Persons therein towards the cost of this Plan; and (4) the right to amend this Plan or any term or condition thereof; in each case, whether or not such rights are exercised with respect to any other Covered Person or group of Covered Persons in this Plan.
NOT A CONTRACT OF EMPLOYMENT	No provision of the Plan described in this Booklet is to be considered a contract of employment. The Employer's rights with respect to disciplinary actions and termination of Employees are in no way changed by the provisions of the Plan. If You have any questions about the Plan, contact the Plan Administrator.

IMPORTANT PLAN EFFECTIVE DATES

Plan Effective Date:	January 1, 2004	
Plan Benefit Year:	January 1st through December 31st	
Plan Renewal Date:	This Plan has four (4) renewal dates: **January 1st** or **April 1st** or **July 1st** or **October 1st** *Depending on when Your Employer first elected coverage.*	
Plan's Annual Open Enrollment:	For January Renewals:	December 1 - December 31
	For April Renewals:	March 1- March 31
	For July Renewals:	June 1 - June 30
	For October Renewals:	September 1 - September 30
Date of Last Restatement/Revision:	July 1, 2019	

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DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Actively at Work means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Participating Employer's place of business, or at any other place that the Participating Employer's business requires the Employee to go.

Adverse Benefit Determination is a denial of Your claim, in whole or in part, a reduction in or termination of benefits, or a failure to provide payment for a benefit.

Ambulance means a certified transportation vehicle for transporting ill or injured people that contains all life-saving equipment and staff as required by applicable state and local law.

Ambulatory Surgical Center is a Facility mainly engaged in performing Outpatient Surgery. It must be staffed by Physicians and Nurses, under the supervision of a Physician, have operating and recovery rooms, be staffed and equipped to give Emergency care, and have written backup arrangements with a local Hospital for Emergency care. It must carry out its stated purpose under all relevant state and local laws and be either: accredited for its stated purpose by either The Joint Commission or the Accreditation for Ambulatory Care or approved for its stated purpose by Medicare. A Facility is not an Ambulatory Surgical Center, for the purpose of this document, if it is part of a Hospital.

Ambulatory surgery is surgery that does not require an overnight hospital stay.

Annual Open Enrollment Period is the 30-day period prior to the Plan's Renewal Date. During the Annual Open Enrollment Period, Covered Persons' and their Dependents will have the opportunity to change their level of coverage or choose between Plans offered. Benefit choices made during the Annual Open Enrollment Period will become effective on the Plan's Renewal Date and remain in effect for 12 months, unless there is a Qualifying Event. Refer to General Plan Information for this Plan's Annual Open Enrollment Period and Renewal date.

Approved Cancer Clinical Trial means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:

1) The treatment or intervention is provided pursuant to an Approved Cancer Clinical Trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an Investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
2) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
3) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
4) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
5) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the Federal entities identified in item a. A cost-benefit analysis of Clinical Trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.

Automobile Related Injury means bodily Injury sustained by a Covered Person as a result of an accident: while occupying, entering, leaving or using an automobile; or as a pedestrian; caused by an automobile or by an object propelled by or from an automobile.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Behavioral Health Provider is an individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for Mental Health Conditions and Substance Use Disorders, under the laws of the jurisdiction where the individual practices.

Benefit Plan(s) are the specific details, rules, and provisions of covered benefits provided under the Plan.

Benefit Plan Year is the 12 - month period beginning each January 1st or on the day following the end of the first Plan Year that is a short Plan Year, i.e., one that starts on a date other than January 1. This is the date by which all Plan Deductibles, Plan maximums, visit maximums, etc., are tracked. Refer to General Plan Information for this Plan's Benefit Year Effective Date.

Birthing Center means any freestanding health Facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located, approved for its stated purpose by the Accreditation Association for Ambulatory Care, and approved for its stated purpose by Medicare.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered Nurse (R.N.) or a licensed Nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

The Plan covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and postpartum care in connection with a Covered Person's Pregnancy. The Plan covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non- Covered Charge. The Plan covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Calendar Year means January 1st through December 31st of the same year.

Childbirth includes both labor (the process of birth) and delivery (the birth itself); it refers to the entire process as an infant makes its way from the womb down the birth canal to the outside world.

Chiropractic Services/Spinal Manipulation means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Civil Union is a legal union of a same-sex couple, sanctioned by a civil authority.

Claims Administrator means any entity, insurance company, or service provider retained by the Plan to administer claims submission, adjudication, processing and/or payment on behalf of the Plan.

Clinical Trial is defined as a Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of cancer or other life-threatening Condition or disease (or other Condition described in ACA, such as Federally funded trials, trials conducted under an Investigational new drug application reviewed by the FDA or drug trials exempt from having an Investigational new drug application). A life-threatening Condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. The Plan does not cover the cost of Clinical Trials. However, the Plan covers routine costs for patients enrolled in Clinical Trials for life- threatening diseases, for services that would normally be covered, i.e., lab work and diagnostic testing. These services are covered by the Plan and are subject to In-Network and Out-of-Network Provider benefits.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. However, the Plan will waive the Coinsurance requirement once the Maximum Out-of-Pocket has been reached. Coinsurance does not include Deductibles, Copayments, penalties incurred under this Plan's Medical Management Review provisions, or any other Non-Covered Charge.

Condition is a disease or Illness.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. Note: The Emergency Room Copayment, if applicable, must be paid in addition to the Deductible, any other Copayments, and Coinsurance.

Cosmetic Surgery is any Surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate/ Medical Necessity and Appropriateness.

Covered Charges are Allowed Charges for the types of services and supplies described in the Plan Provisions. The services and supplies must be:

1) furnished or ordered by a recognized health care Provider; and
2) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Plan, the Plan pays benefits for Covered Charges incurred by a Covered Person while he or she is covered by this Plan. Read the entire Plan to find out what the Plan limits or excludes.

Covered Person means an eligible Employee or a Dependent who is covered and enrolled in this Plan.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Even if a Covered Person is in a Hospital or other recognized Facility, the Plan does not pay for that part of the care which is mainly custodial.

Deductible means annual amount of money that is paid once a **Calendar Year** per Covered Person. It must be paid before any money is paid by this Plan for any covered services (with a few exceptions). The Deductible is based on the benefit year and each January 1st, a new Deductible amount is required. The Deductible is in addition to any Hospital admission Deductible or Hospital outpatient visit Deductible (if and when applicable) as shown in the Schedule of Benefits. Deductible does not include Coinsurance, Copayments and Non-Covered Charges.

Embedded Deductible means if You are on a family medical plan with an embedded Deductible, Your Plan contains two components, an individual Deductible and a family Deductible. Having two components to the Deductible allows for each member of Your family the opportunity to have Your Plan pay the health care expenses prior to the entire dollar amount of the family Deductible being met. The individual Deductible is embedded in the family Deductible.

You can satisfy the family Embedded "Deductible" or the family Embedded “Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family member and then any combination of family members may satisfy the remaining amount. No more than the individual amount will be credited to the family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year. Refer to the Schedule of Benefits for Individual and Family amounts.

Aggregating Deductible (HSA Compatible Plans have this Deductible) means there is not an individual Deductible embedded in the family Deductible. Before Your Plan starts to cover their portion of Your medical bills, the entire amount of the family Deductible must be met first. It can be met by one family member or a combination of family members; however, there are no costs covered by Your health Plan until costs equaling the family Deductible amount have been incurred.

You can only satisfy the family Aggregating "Deductible" or the family Aggregating “Maximum Out-of-pocket" by meeting the family amount if You have family, Employee+Child(ren), or Employee+spouse coverage. The Plan doesn’t begin paying for the health care expenses of anyone in the family until the entire family Deductible has been met. If You have individual coverage, the Plan doesn’t begin paying for health care expenses until the individual Deductible has been met. Refer to the Schedule of Benefits for Individual and Family amounts.

Dependent. A Dependent is any one of the following persons:

1) **Legal Spouse**. The term “*Spouse*” shall mean the person recognized as the Covered Person‘s husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator requires a certified copy of a marriage certificate.
2) **Domestic Partner.** Domestic Partners, of any gender, who have been living in a committed exclusive relationship of mutual caring and support with the Covered Person for a period of 12 months, who intend for the Domestic Partnership to be permanent are covered under this Plan, provided that they meet the following proof requirements. It is required that You provide three documents evidencing the commitment of the relationship. The following

documentation for coverage of a Domestic Partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Covered Person's will; durable power of attorney for healthcare or financial management; Joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party. You may be required to sign an agreement with the Plan that You provide the Plan with notice within 31 days of a break in the Domestic Partnership.

3) **Civil Union Partner.** Pursuant to P.L. 2006, c.103. Civil Union couples are granted all of the same rights as married couple. The Plan requires a copy of the Civil Union Certificate. Civil Union couples do not have to meet Domestic Partner guidelines or provide proof requirements of Domestic Partnership.
4) **Unmarried Child(ren) up to Age 31.** A Dependent is eligible for coverage up to age 31 from the first day that he or she meets the Dependent definition below if they are between the age of 26 and 31. These Dependents will be subject to a discount of the single Healthcare Fee rate charged for the Plan in which they are enrolled in and will be covered until their 31st birthday or until the last day of the month for which the required payment has been made, whichever comes first.
5) **Child(ren)** who have not attained age 26 will be eligible for coverage under the Plan**.** Documentation showing eligibility, including but not limited to, birth certificates, records of relevant legal proceedings, separation and divorce decrees must be provided.

   The term "*Children*" or "*Child*" shall include natural Children, adopted Children, Civil Union Partner's Children, Domestic Partner's Children, foster Children or Children placed with an Employee in anticipation of adoption or of the Child's becoming an Employee's foster Child. Step-Children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

   The phrase "*Child placed with a covered Employee in anticipation of adoption*" refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption.

   The term "*placed*" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. Coverage of these pre-adoptive Children is in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993. The Child must otherwise be available for adoption and the legal process must have commenced.

   If a Covered Person is the Legal Guardian of an unmarried Child or Children, these Children may be enrolled in this Plan as covered Dependents.

   Any Child of a Covered Person who is an alternate recipient under a qualified medical Child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these Children is in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical Child support order procedures are available upon request.

6) **Legal Guardianship.** Should the Covered Person have a court-appointed Legal Guardianship and is within 30 days of the date Legal Guardianship is granted, coverage for the Child becomes effective the date the Legal Guardianship is granted. A Child for whom the Employee acquires Legal Guardianship but does not apply to enroll until more than 30 days after the date Legal Guardianship is granted, will not be eligible until the next Annual Enrollment Period.

7) **Totally Disabled Dependent Child.** A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of Mental Health Conditions, intellectual disability or physical handicap, primarily Dependent upon the Covered Person for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

   After such two-year period, the Plan may require subsequent proof not more than once each year. The Plan reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Dentist. A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Dependent's Eligibility Date means the later of: a) the Employee's Eligibility Date; or b) the date the person first becomes a Dependent.

Determination/Determine means the Plan's right to make a decision or Determination. The decision will be applied in a reasonable and non-discriminatory manner.

Developmental Disability or **Developmentally Disabled** means a severe, chronic disability that:

1) is attributable to a Mental Health Conditions or physical impairment or a combination of Mental Health Conditions and physical impairments;
2) is manifested before the Covered Person:
3) attains age 26 for all other provisions;
4) is likely to continue indefinitely;
5) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
6) reflects the Covered Person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of 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.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific Condition or disease. Some examples are: a) radiology, ultrasound and nuclear medicine; b) laboratory and pathology; c) EKGs, EEGs and other electronic diagnostic tests. Except as allowed under the Preventive Care Benefit, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the Plan's right to decide or act according to the Plan's own judgment; freedom of judgment or choice. The Plan's discretion will be applied in a reasonable and non-discriminatory manner.

Domestic Partners means two individuals, who have been living in a committed exclusive relationship of mutual caring and support for a specified time period, who intend for the Domestic Partnership to be permanent, who are financially interdependent and jointly responsible for the common welfare and financial obligations of the household and who are not in the relationship solely for purposes of obtaining benefits but who are not married under applicable law. Domestic Partners shall include Domestic Partner pursuant to P.L. 2003, c. 246.

Domestic Partnership means an interpersonal relationship between two individuals who live together and share a common domestic life but are not married.

Drugs means Drugs as determined by the Food and Drug Administration and listed in the Formulary of the state in which they are dispensed; these Drugs are protected by the trademark registration of the pharmaceutical company which produced them.

Durable Medical Equipment means Equipment the Plan Determines to be:

1) designed and able to withstand repeated use;
2) used primarily and customarily for a medical purpose;
3) is generally not useful to a Covered Person in the absence of an Illness or Injury; and
4) is suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood glucose monitors, insulin pumps, breathing equipment, oxygen, Hospital type beds, orthotics, prostheses, walkers, wheelchairs, wigs following Chemotherapy treatment in connection with oncology services, as well as hearing aids which are covered through age 15.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Covered Person's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

Effective Date means the date on which coverage begins under this Plan for the Participating Employer, or the date coverage begins under this Plan for an Employee or Dependent, as the context in which the term is used suggests.

Emergency means a medical Condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbance and/or symptoms of Substance Use Disorders such that a prudent layperson, who

possesses an average knowledge of health and medicine, could expect the absence of immediate attention to result in: placing the health of the individual (or with respect to a pregnant woman, that health of the woman or her unborn Child) in serious jeopardy: serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an Emergency exist where: where is inadequate time to affect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn Child. Examples of Medical Emergencies include, but are not limited to: heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness or respiration.

Employee means a Full-Time bona fide Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Plan. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are not employees of the Employer.

Employee Open Enrollment Period means the 30-day period each year designated by the Participating Employer during which: a) Employees and Dependents who are eligible under the Plan but who are Late Enrollees may enroll for coverage under the Plan; and b) Employees and Dependents who are covered under Plan may elect coverage under a different Plan, if any, offered by the Participating Employer.

Employer a person or business that employs one or more people, especially for wages or salary.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, is the first day of coverage or, if there is a Waiting Period, the first day following the end of the Waiting Period, if any.

ERISA is the Federal Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits means Essential Health Benefits under section 1302(b) of the Affordable Care Act (ACA) and applicable regulations. Section 1302(b) of ACA defines such benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; Mental Health Conditions and Substance Use Disorders services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; Preventive Care services and chronic disease management; and pediatric services including pediatric oral and vision care.

Experimental and/or Investigational means Services or supplies which the Plan determines are:

1) not of proven benefit for the particular diagnosis or treatment of a Covered Person's particular Condition; or
2) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Covered Person's particular Condition; or
3) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to Drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the Plan will not cover any services or supplies, including treatment, procedures, Drugs, biological products or medical devices or any Hospitalizations in connection with Experimental or Investigational services or supplies.

The Plan will also not cover any technology or any Hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Covered Person's particular Condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Covered Person's particular Condition, as explained below. The Plan will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

1) Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or Condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or Condition, use of the medical device, drug or biological product for another diagnosis or Condition will require that one or more of the following established reference compendia recognize the usage as appropriate medical treatment:
   a) The American Hospital Formulary Service Drug Information; or
   b) The United States Pharmacopoeia Drug Information
2) Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a

definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3) Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4) Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5) Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard Conditions of medical practice, outside clinical investigatory settings.

Extended Care Center (see "Skilled Nursing Facility").

Facility means a place the Plan is required by law to recognize which:

1) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
2) provides health care services which are within the scope of its license, certificate or accreditation.

Fee Schedule is any negotiated, discounted or per diem rate or fee that the Network may have with a particular Provider. See, also Plan's Allowable Charges.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by a Plan or issuer at the completion of the internal appeals process applicable under the section Adverse Benefit Determination with respect to which the internal appeals process has been exhausted.

Full-Time means a normal work week of 24 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and Genetic Information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Gestational Carrier is a female carrying an embryo to which she is not genetically related.

Group Health Plan means an Employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. § 1002(1)) to the extent that the Plan provides medical care and includes items and services paid for as medical care to Employees or their Dependents directly or through insurance, reimbursement or otherwise.

Health Benefits Plan means any Hospital and medical expense insurance policy or certificate; health, Hospital, or medical service corporation contract or certificate; or health maintenance organization Subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or Plan issued to a Small Employer, not explicitly excluded from the definition of a Health Benefits Plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health Benefits Plan shall not include

Hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Care Fees are the cost per Covered Person paid for coverage of medical, prescription and/or dental benefits for a defined benefit period.

Health Plan Participation Request/Contract means an agreement between (i) the Trust and
(ii) a Covered Person, pursuant to which the Covered Person agrees to participate in the Trust, agrees to be bound by the terms of the Trust Agreement and identifies Eligible Beneficiaries (affiliated with such Covered Person) or sets forth the means of identifying such Eligible Beneficiaries, "Covered Persons" under this Plan.

Home Health Agency means a Provider which provides Skilled Nursing Care for ill or Injured people in their home under a home Healthcare program designed to eliminate Hospital stays. The Plan will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is Federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written Plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered Nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and Speech Therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a Hospice care program. The Plan will recognize a Hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

1) approved for its stated purpose by Medicare; or
2) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a Plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed Facility, home care, and family counseling during the bereavement period.

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by The Joint Commission; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered Nurses (R.N.s); and it is operated continuously with organized facilities for operative Surgery on the premises.
The definition of "Hospital" shall also include the following:

1) A Facility operating legally as a Psychiatric Hospital or Residential Treatment Facility for Mental Health Conditions and licensed as such by the state in which the Facility operates.
2) A Facility operating primarily for the treatment of Substance Use Disorders if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered Nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Incapacitated Child(ren) is a Child who is temporarily or permanently impaired by mental and/or physical deficiency, disability, Illness, or by the use of Drugs to the extent the Child lacks sufficient understanding to make rational decisions or engage in responsible actions.

Independent Review Organizations (IROs) are entities that conduct independent external reviews of Adverse Benefit Determination s involving appropriateness of care, Medical Necessity criteria, level of care, and effectiveness of a requested service.

Illness means a bodily disorder, disease, physical Sickness or Mental Health Conditions. Illness includes Pregnancy, Childbirth, miscarriage or Complications of Pregnancy.

In-Network or Network Provider is a Physician, Hospital, or other health care Provider who is contracted with the Plan's Provider network to provide services to Plan members for specific pre-negotiated rates.

Infertility is a Condition that results in the abnormal function of the reproductive system such that a person is unable to:
1) impregnate another person;
2) conceive after unprotected intercourse;
3) carry a Pregnancy to live birth.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized Healthcare Facility; or services and supplies provided in such settings.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

Joint Commission means the Joint Commission on the Accreditation of Healthcare Organizations.

Late Enrollee means a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan with or without interruption. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from:
1) a Participating Mail Order Pharmacy by ordering the Drugs through the mail or
2) a Participating Pharmacy that has agreed to accept the same terms, Conditions, price and services as a Participating Mail Order Pharmacy.

Maximum Out-of-Pocket (MOOP) is the annual dollar amount that a Covered Person must pay out in any Calendar Year and includes copays, Deductible, and Coinsurance. Once the MOOP is met the Covered Person has no additional out-of-pocket costs for the remainder of the year. However, Medical Precertification penalties and amounts above the Plan's Allowable Charge are not considered Covered Charges and do not accrue to the MOOP.

Medicaid is the Healthcare program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medical Care Facility means a Hospital, a Facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Management Review Administrator assists individuals with treatment needs that extend beyond the acute care setting. The goal of the Medical Management Review Administrator is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an Inpatient in a Hospital or specialized Facility.

Medical Necessity and Appropriateness/Medically Necessary and Appropriate is services or supplies, provided by a recognized Healthcare Provider that are determined to be:

1) necessary for the symptoms and diagnosis or treatment of the Condition, Illness or Injury;
2) provided for the diagnosis or the direct care and treatment of the Condition, Illness or Injury;
3) in accordance with generally accepted medical practice;
4) not for the convenience of the Covered Person or Provider of medical services;
5) the most appropriate level of medical care that a Covered Person needs; and
6) furnished within the framework of generally accepted methods of medical management currently used in the United States. In the instance of a Medical Emergency, the fact that a Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not necessarily make the services Medically Necessary and Appropriate.

Not all Medically Necessary and Appropriate services or supplies are covered. Please refer to the Plan Exclusions section of this Summary Plan Description.

Medical Precertification is the Plan's process of authorizing services by reviewing related documentation, verifying benefits and Medically Necessary and Appropriateness and ensuring the appropriate Provider will be delivering the services. Medical Precertification is defined as approval from the Plan prior to the patient receiving services. Emergency admissions require Medical Precertification within 48 hours. Services and supplies which are not Precertified are subject to the penalties described within the Medical Management Services section of this Summary Plan Description.

Medical Record Review is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan may determine the maximum Plan's Allowable Charge according to the Medical Record Review and audit results.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Conditions means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Facility means a Facility which mainly provides treatment for people with Mental Health Conditions. The Plan will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either: a) accredited for its stated purpose by the Joint Commission; b) approved for its stated purpose by Medicare; or c) accredited or licensed by the state of New Jersey to provide Mental Health Conditions services.

Morbid Obesity is a diagnosed Condition in which the body weight exceeds the medically recommended weight. This is determined when a Covered Person has a body mass index (BMI) of greater than or equal to 40 kilograms per meter squared, or a BMI of greater than or equal to 35 kilograms per meter squared with a high-risk of comorbid Condition.. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

Multiple Employer Welfare Arrangement (MEWA) is a self-funded arrangement for the provision of health care benefits established by one or more unrelated Employers. A MEWA is subject to ERISA and, in New Jersey, by the provisions of the Self-Funded Multiple Employer Welfare Regulation Act (NJSA 17B: 27C-1, et seq. and the regulations promulgated pursuant to it).

Network or In-Network Provider is a Physician, Hospital, or other health care Provider who is contracted with the Plan's Provider network to provide services to Plan members for specific pre-negotiated rates.

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.
For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long-term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Plan's definition of Covered Charges or which exceed any of the benefit limits shown in this Plan, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Plan.

Non-Emergent Services are services that do not require immediate attention and are not life-threatening Condition. Examples of Non- Emergent Services include but are not limited to: scheduled medical appointment or Surgery, dialysis, chemotherapy, physical therapy, influenza, routine services.

Nurse means a registered Nurse or licensed practical Nurse, including a Nurse specialist such as a mid-wife or Nurse anesthetist, who:

1) is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and
2) provides medical services which are within the scope of his or her license or certificate and are covered by this Plan.

Orally Administered Anti-Cancer Prescription Drugs. As used in this provision, Orally Administered Anti-Cancer Prescription Drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer Prescription Drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Plan.

The Plan covers Orally Administered Anti-Cancer Prescription Drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Provider who writes the prescription for such Prescription Drugs. The Plan covers Orally Administered Anti-Cancer Prescription Drugs that are Medically Necessary and Appropriate as Out-of-Network Services and Supplies if the Covered Person is receiving care and treatment from an Out-of- Provider who writes the prescription for such Prescription Drugs.

Anti-cancer prescription Drugs are covered subject to the terms of the Prescription Drugs provision of the Plan as stated above. The Covered Person must pay the Deductible and/or Coinsurance required for Prescription Drugs. Using the receipt from the Pharmacy, the Covered Person may then submit a claim for the anti-cancer Prescription Drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Plan. Upon receipt of such a claim the Plan will compare the coverage for the orally-administered anti-cancer prescription Drugs as covered under the Prescription Drugs provision to the coverage the Plan would have provided if the Covered Person had received intravenously administered or injected anti-cancer medications (from the Network or Out-of-Network Provider, as applicable) to determine which is more favorable to the Covered Person in terms of Copayment, Deductible and/or Coinsurance. If the Plan provides different Copayment, Deductible or Coinsurance for different places of service, the comparison shall be to the location for which the Copayment Deductible and Coinsurance is more favorable to the Covered Person. If a Covered Person paid a Deductible and/or Coinsurance under the Prescription Drug provision that exceeds the Copayment, Deductible and/or Coinsurance that would have applied for intravenously administered or injected anti-cancer medications the Covered Person will be reimbursed for the difference.

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Out-of-Network Elective Services means a Covered Person chooses services that are provided by an Out-Of-Network Provider and are Non-Emergent in nature.

Out-of-Network or Out-of-Network Provider is a Physician, Hospital, or other health care Provider, who is not contracted to participate with the Plan's Provider network.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray Facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of Mental Health Conditions or Substance Use Disorders when there is reasonable expectation for improvement or when it is necessary to

maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric Facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the Facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Participating Employer is each individual Employer who has purchased coverage for its eligible Employees under the Trust by completing and agreeing to the terms and conditions of the Health Plan Participation Request/Agreement.

Participating Mail Order Pharmacy means a licensed and registered Pharmacy operated by ESI or with whom ESI has signed a Pharmacy service agreement, that is:

1) equipped to provide Prescription Drugs through the mail; or
2) is a Participating Pharmacy that is willing to accept the same Pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.

Participating Pharmacy means a licensed and registered Pharmacy operated by the Plan or with whom the Plan has signed a Pharmacy services agreement.

Patient Protection and Affordable Care Act (PPACA) is a United States Federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other Physician of the healing arts who is licensed and regulated by a state or Federal agency and is acting within the scope of his or her license.

Plan means Members Health Plan NJ, which provides Benefit Plans for certain Covered Persons of the Trust and is described in this document.

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act
of 1974" (ERISA) (29 U.S.C. § 1002(16)(B)). That is:

1) the Small Employer in the case of an Employee benefit Plan established or maintained by a single Employer;
2) the Employee organization in the case of a Plan established or maintained by an Employee organization; or
3) in the case of a Plan established or maintained by two or more Employers or jointly by one or more Employers and one or more Employee organizations, the association, committee, joint board of Trustees, or other similar group of representatives of the parties who establish or maintain the Plan.

Plan Year means the year that is designated as the Plan Year in the Plan document of a Group Health Plan, except if the Plan document does not designate a Plan Year or if there is no Plan document, the Plan Year is a Calendar Year.

Plan's Allowable Charges are charges that do not exceed the maximum dollar amount the Plan will recognize for a covered service, procedure or supply.

For all In-Network services the Plan will pay based on the contracted rate between the Provider and the Plan. The In-Network Provider cannot collect more than the contracted rate between Plan payment and Covered Person responsibility of Deductible, copay and/or Coinsurance, if applicable.

For all Out-of-Network Elective and Non-Emergent Services the Plan will pay according to the Plan's Allowable Charges calculated in accordance with the following:

Service or Supply	**Plan's Allowable Charges**
Professional services and other services or supplies not mentioned below	110% of the Medicare/RBRVS* allowable rate

Inpatient and outpatient charges of Hospitals	140% of the Medicare/RBRVS* allowable rate
Inpatient and outpatient charges of facilities other than Hospitals	
Drugs purchased through the Medical Plan	110% of the average wholesale price (AWP)

*If there is not a Medicare rate for a specific service, an allowable amount is determined based on the medical Claims Administrator review and approval of comparable services and recommendations.

Important note: If the Provider bills less than the amount calculated using the Plan's Allowable Charges described above, the Plan's Allowable Charges is what the Provider bills. The Out-of-Network Provider can collect the difference of their billed amount and total paid amount, unless there is a previously established agreement to accept total paid amount as payment in full. Charges in excess of the Plan's Allowable Charges are not considered Covered Charges under the Plan and do not accrue towards Your Maximum Out-of-Pocket allowance**.**

The **Plan's Allowable Charges** do not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network Facility by an Out-of-Network Provider that You did not choose, unless that Out-of-Network Provider is an assistant surgeon for Your surgery
- Not available from a Network Provider
- Emergency services

We will calculate Your cost share for involuntary services in the same way as We would if You received the services from a network Provider.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by the prescription Claims Administrator).
- Facility charge review (FCR) rate is an amount that the Plan determine is enough to cover the Facility **Provider's** estimated costs for the service and leave the Facility **Provider** with a reasonable profit. For **Hospitals** and other facilities that report costs (or cost-to-charge ratios) to Centers for Medicare and Medicaid Services' (CMS), the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. The Plan may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, the Plan may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of Facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates the CMS establishes for services and supplies provided to Medicare enrollees. The medical Claims Administrator updates their systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, they use one or more of the items below to determine the rate:
    - The method CMS uses to set Medicare rates,
    - What other Providers charge or accept as payment,
    - How much work it takes to perform a service,
    - Other things as needed to decide what rate is reasonable for a particular service or supply.

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to Hospitals or other Providers. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For DME, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies:
We reserve the right to apply our reimbursement policies to all Out-of-Network services including involuntary services. Our reimbursement policies may affect the **Plan's Allowable Charges**.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **Provider**

Our reimbursement policies may consider:

- The CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **Physicians** and dentists practicing in the relevant clinical areas
- Medical Claims Administrators own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and Facility services.

Get the most value out of Your benefits
The Plan offers online tools to help You decide where to get care. You can use the medical Claims Administrator's "Estimate the Cost of Care" tool on Aetna Navigator®. Aetna's secure member website at www.aetna.com may contain additional information that can help You determine the cost of a service or supply. Log on to Aetna Member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Podiatric Care means treatment of Illness or deformity below the ankle but does not include dislocations or fractures of the foot.

Practitioner means a person the Plan is required by law to recognize who:

1) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
2) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board- Certified Behavior Analyst – Doctoral or as a Board-Certified Behavior Analyst.

Preferred Drug means a Prescription Drug that; a) has been designated as such by either the Plan, or a third party with which ESI contracts, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Covered Persons, upon request. The list of Preferred Drugs will be revised, as appropriate.

Pregnancy is Childbirth and Conditions associated with Pregnancy, including complications.

Prescription Drugs – Drugs, biologicals and compound prescriptions that are sold only by prescription and are required to show on the manufacturer's label the words "Caution-Federal Law Prohibits Dispensing Without a Prescription," or other Drugs and devices as determined by the Plan, such as insulin, hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary and Appropriate in the treatment of a Sickness or Injury. The Plan covers only Drugs that are:

1) Approved for treatment of Your Illness or Injury by the Food and Drug Administration (FDA):
2) Approved by the FDA for the treatment of a particular diagnosis or Condition other than Your Condition, and recognized as appropriate medical treatment for Your diagnosis or Condition in one or more of the following

established reference
compendia: “The American Hospital Formulary Service Drug Information” or “The United States Pharmacopoeia Drug Information;” or
3) Recommended by a clinical study and by a review article in a major peer-reviewed professional journal.

The Plan does not pay for Drugs that are limited by Federal law for Investigational use, or any use which the FDA determines to be contraindicated for the specific treatment for which the drug is prescribed.

Prescription Precertification for Prescription Drugs is required when your Plan requires your physician to get specific medications approved by the Pharmacy benefit manager. Precertification must be provided before the Plan will provide full (or any) coverage for those medications.

Preventive Care. As used in this Plan Preventive Care means:

1) Evidence based items or services that are rated “A” or “B” in the current recommendations of the United States Preventive
Services Task Force with respect to the Covered Person;
2) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;
3) Evidence–informed Preventive Care and screenings for Covered Persons who are infants, Children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
4) Evidence–informed Preventive Care and screenings for female Covered Persons as included in the comprehensive guidelines supported by the Health Resources and Services Administration, except for contraceptive services and supplies; and
5) Any other evidence-based or evidence-informed items as determined by Federal and/or state law.

Examples of Preventive Care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

Primary Care Provider (PCP). An In-Network Provider who is a Physician specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Covered Person; initiates a Covered Person's specific direction or instruction for Specialist Services (if required); and is responsible for maintaining continuity of patient care. Primary Care Providers include Nurse Practitioners/clinical Nurse specialists, Physician assistants and certified Nurse midwives.

Please note: Plans do not require the selection of a PCP.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered Nurse or a licensed practical Nurse.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

Provider means a recognized Facility or Practitioner of Healthcare in accordance with the terms of this Plan.

Psychiatric Hospital

An institution specifically licensed or certified as a Psychiatric Hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, or Mental Health Conditions (including Substance Use related Disorders).

Qualified Continuee can be

1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee.
2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order.

The term "covered Employee" includes not only common-law Employees but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event means the following dates:

1) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of Healthcare Fees, fraud or misrepresentation of material fact shall not be a Triggering Event.
2) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
3) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the Federal government or Plan.
4) The date an Employee or eligible Dependent demonstrates to the marketplace or a State regulatory agency that a qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
5) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move provided the Employee and/or Dependent demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
6) The date NJ Family Care determines an Employee or Dependent who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that Determination is made after the open enrollment period or Special Enrollment Period ends.
7) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
8) The date the Employee or Dependent loses eligibility for Medicaid or NJ Family Care.
9) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ Family Care plan.
10) The date of a court order that requires coverage for a Dependent.

RBRVS means Resource-Based Relative Value Scale that is a schema used to determine how much money a medical Provider should be paid. It is partially used by Medicare in the United States and by nearly all health maintenance organizations (HMOs). RBRVS assigns procedures performed by a Physician or other medical Provider a relative value which is adjusted by geographic region. This value is then multiplied by a fixed conversion factor, which changes annually, to determine the amount of payment.

Reasonable and Customary (see Plan's Allowable Charges).

Referral means specific direction or instruction from a Covered Person's Primary Care Physician in conformance with the Plan's policies and procedures that directs a Covered Person to a Facility or Provider for health care**.**
Please note: Plans do not require Referral for services.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

1) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
2) approved for its stated purpose by Medicare. In some places, a Rehabilitation Center is called a "rehabilitation Hospital."

Renewal Date for this Plan is every January 1st, April 1st, July 1st, or October 1st depending on when the Participating Employer first elected coverage. For example, if a Participating Employer first enrolled on February 1, the Participating Employers Renewal Date will be every January 1st from thereafter. Plan changes may only be made at a Participating Employer's Renewal Date.

Residential Treatment Facility (Mental Health Conditions)

- An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for Mental Health Conditions residential treatment programs. And is credentialed by the Network or is accredited by one of the following agencies, commissions or committees for the services being provided:
    - The Joint Commission (TJC)
    - The Committee on Accreditation of Rehabilitation Facilities (CARF)
    - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
    - The Council on Accreditation (COA)

- In addition to the above requirements, an institution must meet the following for residential treatment programs treating Mental Health Conditions:
    - A Behavioral Health Provider must be actively on duty 24 hours per day for 7 days a week.
    - The patient must be treated by a psychiatrist at least once per week.
    - The medical director must be a psychiatrist.
    - Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).

Residential Treatment Facility (Substance Use Disorders)

- An institution specifically licensed as a Residential Treatment Facility by applicable state and federal laws to provide for Substance Use Disorders residential treatment programs. And is credentialed by the Network or accredited by one of the following agencies, commissions or committees for the services being provided:
    - The Joint Commission (TJC)
    - The Committee on Accreditation of Rehabilitation Facilities (CARF)
    - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
    - The Council on Accreditation (COA)

- In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:
    - A Behavioral Health Provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
    - The medical director must be a Physician.
    - Is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution.)
- In addition to the above requirements, for chemical dependence detoxification programs within a residential setting:
    - An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting.
    - Residential care must be provided under the direct supervision of a Physician.

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, hemolata, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, teratoma, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot Orthotic Appliances and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule of Benefits refers to the outline of covered benefits as shown in the Plan.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse or licensed practical Nurse and require the technical skills and professional training of a registered Nurse or licensed practical Nurse.

Skilled Nursing Facility is a Facility that fully meets all of these tests:

1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered Nurse (R.N.) or by a licensed practical Nurse (L.P.N.) under the direction of a registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2) Its services are provided for compensation and under the full-time supervision of a Physician.

3) It provides 24-hour per day nursing services by licensed Nurses, under the direction of a full-time registered Nurse.
4) It maintains a complete medical record on each patient.
5) It has an effective Medical Management Review plan.
6) It is not, other than incidentally, a place for rest, the aged, drug addicts, mental retardates, Custodial or educational care or care of Mental Health Conditions.
7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a Facility referring to itself as an extended care Facility, convalescent nursing home, rehabilitation Hospital or any other similar nomenclature.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an Employer who employed an average of at least 1 but not more than 50 Employees on business days during the preceding Calendar Year and who employs at least 1 Employee on the first day of the Plan Year. All persons treated as a single Employer under subsection (b), (c), (m) or of section 414 of the Internal Revenue Code of 1986 shall be treated as one Employer. In the case of an Employer which was not in existence throughout the preceding Calendar Year, the Determination of whether such Employer is a small or large Employer shall be based on the average number of Employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an Employer employs at least 1 but not more than 50 Employees. For purposes of this calculation:
1) Employees working 30 or more hours per week are Full-Time Employees and each Full-Time Employee counts as 1;
2) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of Full-Time Employees to the number that results from the part-time Employee calculation. If the sum is at least 1 but not more than 50 the Employer employs at least 1 but not more than 50 Employees.

Special Enrollment Period means a period of time that is no less than 30 days or 60 days, as applicable, following the date of a Triggering Event during which:
1) Late Enrollees are permitted to enroll under the Participating Employer's coverage; and
2) Covered Persons who already have coverage are permitted to replace current coverage with coverage under a different plan, if any, offered by the Employer.

Specialist Physician is a Physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialist Services Medical care in specialties other than family practice, general practice, internal medicine or pediatrics or obstetrics/gynecology (for routine pre- and post-natal care, birth and treatment of diseases and hygiene).

Subscriber is a person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom Health Care Fees have been received.

Substance Use Disorders means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders

Substance Use Disorders Facility are Facilities that mainly provide treatment for people with Substance Use Disorders problems. The Plan will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
1) accredited for its stated purpose by the Joint Commission; or
2) approved for its stated purpose by Medicare.

Surgery is defined as:
1) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures; or
2) the correction of fractures and dislocations; or
3) pre-operative and post-operative care; or
4) any of the procedures designated by Current Procedural Terminology codes as Surgery.

Surrogate is a female carrying her own genetically related Child where the Child is conceived with the intention of turning the Child over to be raised by others, including the biological father.

Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

Telemedicine means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Therapeutic Manipulation is the Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical Conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

Therapy Services The following services or supplies ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

- **ABA Therapy -** behavioral interventions based on the principles of applied behavioral analysis (ABA) and related to structured behavioral programs for the treatment of autism.
- **Cardiac Rehabilitation Therapy -** program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.
- **Chelation Therapy -** the administration of Drugs or chemicals to remove toxic concentrations of metals from the body.
- **Chemotherapy –** the treatment of malignant disease by chemical or biological antineoplastic agents.
- **Cognitive Rehabilitation Therapy -** retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic processes.
- **Dialysis Treatment -** the treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
- **Infusion Therapy -** the administration of antibiotic, nutrients or other therapeutic agents by direct infusion.
- **Occupational Therapy -** treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
- **Physical Therapy -** the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.
- **Radiation Therapy -** the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
- **Respiration Therapy -** the introduction of dry or moist gases into the lungs.
- **Speech Therapy -** treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Tier is the benefit level for a specific type of service, not to be confused with the Network. Tier is the benefit level, or how the benefit will be paid, not a Network.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Total Disability to Totally Disabled means, except as otherwise specified in this Plan, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is or may be suited by education, training and experience, and is not in fact, engaged in any occupation for wage or profit. A Dependent is Totally Disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under regular care of a Physician.

Trust means the Affiliated Physicians and Employers Master Trust established by means of a Trust Agreement entered into pursuant to the provisions of the Self-Funded Multiple Employer Welfare Regulation Act (NJSA 17B: 27C-1, et seq.).

Trustees means the Initial Trustees, additional persons elected or appointed as Trustees in accordance with the Trust, and any successors elected or appointed from time to time in accordance with the provisions of the Trust.

Underwriting Guidelines are the Plan's rules and requirements for eligibility for the Plan. The Underwriting Guidelines are available at www.membershealthplannj.com.

Urgent Care includes non-Emergency Conditions for which treatment cannot reasonably be postponed, such as minor cuts, sprains or strep throat.

Urgent Care Facility or Center a Facility, other than a Hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary Charge - A charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area.

Waiting Period means the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the Plan.

We, Us, Ours. Refers to the Plan.

You, Your, and Yours. Refers to the Covered Person.

EXHIBIT A – SCHEDULE OF BENEFITS

The following explanations and Schedule of Benefits provides information on how Your plan works so You can get the most out of Your coverage. But for all the details – and this is very important – You need to read the entire Summary Plan Description and this Schedule of Benefits together. And if You need help or more information, You can call the Plan at the phone number listed on the back of Your ID Card.

How the Plan Works

There are several general requirements for the Plan to pay any part of the expense for a covered service. They are:

- The covered service is Medically Necessary and Appropriate.
- You get the covered service from a Network Provider or Out-of-Network Provider, if applicable.
- You or Your Provider Precertifies the covered service when required.

You will find details on Medical Necessity and Appropriateness and Precertification requirements in the Summary Plan Description.

Each time You need medical attention You choose a **NETWORK PROVIDER** or an **OUT-OF-NETWORK PROVIDER** for Your care.

- **NETWORK PROVIDERS**
  The network consists of Physicians, Specialists, Hospitals and Facilities who participate with the network associated with Your plan (this network can be found on Your Schedule of Benefits below).

  In general, the Plan pays a higher level of benefits when You use Network Providers.

- **OUT-OF-NETWORK PROVIDERS** are Physicians, Specialists, Hospitals and Facilities that do not participate with the network associated with Your plan. Your plan may not offer coverage when You use Out-of-Network Providers, so be sure to verify if Your plan covers Out-of-Network Providers by checking the Schedule of Benefits below. Using Out-of-Network Providers means You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of eligible health services that You paid directly to a Provider. Using Out-of-Network Providers means that when You use out-of-network coverage, it is Your responsibility to start the Precertification process with Providers.

  When You use Out-of-Network Providers, the Plan will not pay more than the Plan's Allowable Charge, which means that You will pay a higher cost share when You use an Out-of-Network Provider. You are responsible for all amounts above the Plan's Allowable Charge.

The Schedule of Benefits lists the Deductibles and Copayments/Coinsurance, if any, that apply to the services You receive under this Plan. You should review this schedule to become familiar with Your Deductibles and Copayments/Coinsurance and any limits that apply to the services.

How to read Your Schedule of Benefits

- When we say:
  - "In-network coverage", we mean You get care from a Network Provider.
  - "Out-of-network coverage", we mean You can get care from Providers who are not Network Providers. Please refer to the Schedule of Benefits to determine if the plan You are enrolled in offers Out-of-network coverage as not all plans have this coverage.
- The Deductibles and Copayments/Coinsurance listed in the Schedule of Benefits below reflect the Deductibles and Copayment/ Coinsurance amounts under Your plan.
- Any Coinsurance listed in the Schedule of Benefits reflects the plan payment percentage. This is the amount the Plan pays. You are responsible to pay any Deductibles, Copayments, and the remaining Coinsurance.
- You are responsible for full payment of any health care services You receive that are not a covered benefit.
- This plan has maximums for specific covered benefits. For example, these could be visit, day or dollar maximums. They are combined maximums between Network Providers and Out-of-Network Providers unless we state otherwise.
- In the schedule You will find detailed explanations about Your:
  - Deductible
  - Maximum out-of-pocket limits
  - Maximums

Important note:
All covered benefits are subject to the Calendar Year Deductible and Copayment/Coinsurance unless otherwise noted in the Schedule of Benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on Your ID card.

This Schedule of Benefits replaces any Schedule of Benefits previously in effect under Your Plan of benefits. Keep this Schedule of Benefits with Your booklet.

PLAN O- NETWORK ONLY 70% PLAN
SCHEDULE OF BENEFITS
No Referrals are Required to see a Specialist

	In-Network Only
Network Providers	Aetna - Open Access Aetna Select
Benefit Plan Year	Calendar Year
Deductible	$2,500/Individual; $5,000/Family (Embedded)
Coinsurance	Plan Pays 70%
Maximum Out-of-Pocket (MOOP)	$6,850/Individual; $13,700/Family (Embedded)
Accumulator Criteria	Deductible and Maximum Out-of-Pocket are combined between In-Network and Out-of-Network, if applicable. Maximum Out-of-Pocket includes any Deductible, Coinsurance, medical Copayments and prescription copay/Coinsurance but does not include non-covered amounts above the Plan's Allowable Charges, or Precertification penalties.
Lifetime Maximum Benefit	Unlimited
Plan Notes/Requirements	Embedded means you can satisfy the Family "Deductible" or the Family “Maximum Out-of-Pocket" with any combination of family members satisfying the amount. However, no one individual may meet more than the individual amount.
Plan Notes/Requirements	Some services listed below may require Precertification. Network Providers should obtain Precertification for you. You are responsible for Precertification for all services by Out-of-Network Providers. A penalty of 50% of the Plan’s Allowable Charge, to a maximum of $10,000 will be applied if Precertification is not obtained. See the Plan’s website at www.membershealthplannj.com for a complete Precertification list.
Plan Notes/Requirements	For all Out-of-Network elective and Non-Emergent Services, there is no coverage.
Physician office visits	
Primary Care Provider office visit	You pay $30 copay/visit
Specialist Physician office visit	You pay $50 copay/visit
Walk In clinic	You pay $30 copay/visit
Gynecological care	
- Routine (Preventive)	Plan pays 100%
- Non-routine	You pay $50 copay/visit
Routine pre-natal care	You pay $30 copay (initial visit only)
Consultations/second opinions	You pay $50 copay/visit
Office based Surgery	After Deductible, Plan pays 70%
Allergy injections and allergy test	
- With office visit	You pay $50 copay/visit
- Without office visit	After Deductible, Plan pays 70%
Preventive Care (wellness office visit)	Plan pays 100%
Preventive Care/screenings	Plan pays 100%
Influenza vaccine	Plan pays 100%
	Preventive and wellness coverage includes reimbursement for routine physical examinations, including related lab tests and x-rays, routine gynecological examination, mammography, pap smear, routine prostate screening & antigen test, glaucoma tests and recommended immunizations as shown at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Emergency services	
Urgent Care Center	You pay $50 copay/visit
Emergency room services	After Deductible and $100 copay/visit, Plan pays 70% (Copay waived if admitted)
Emergency admission	
Authorization required within 48hrs or as soon as reasonably possible. **- Facility/Hospital charges** **- Physician/professional charges**	 $500 copay per admission, after Deductible, then Plan pays 70% After Deductible, Plan pays 70%
Ambulance services ***(Emergent Ambulance services will be covered at In-Network Benefit level)***	After Deductible, Plan pays 70%
Hospital and surgical care	
Inpatient care ***Semi-private hospitalization*** **- Facility/Hospital charges** **- Ancillary/diagnostic charges** **- Physician/professional charges**	 $500 copay per admission, after Deductible, then Plan pays 70% After Deductible, Plan pays 70% After Deductible, Plan pays 70%
Maternity/newborn Inpatient	Refer to Inpatient Benefit. Note that separate cost sharing applies for mother and newborn, including separate Inpatient Hospital Copayment, if applicable.
Inpatient rehabilitation & Skilled Nursing Care ***(60 days per incident maximum)***	$500 copay per admission, after Deductible, then Plan pays 70%
Outpatient Ambulatory Surgery Center **- Facility/Hospital charges** **- Ancillary/diagnostic charges** **- Physician/professional charges**	 After Deductible, Plan pays 70% After Deductible, Plan pays 70% After Deductible, Plan pays 70%
All other Outpatient Care **- Facility/Hospital charges** **- Ancillary/diagnostic charges** **- Physician/professional charges**	 After Deductible, Plan pays 70% After Deductible, Plan pays 70% After Deductible, Plan pays 70%
Pre-admission testing	After Deductible, Plan pays 70%
Transplant services	
Transplant services: Network Facilities that are not designated as IOE Facilities (with Aetna) are considered non participating for transplant services and will be paid at the Out-of-Network benefit, if applicable. If no Out-of-Network benefit, then the services are not covered if IOE Facility is not utilized. **Refer to Core SPD for additional coverage details.**	$500 copay per admission, after Deductible, then Plan pays 70%

Other Outpatient services	
Outpatient Therapy Services (STR) - All therapies *(60 visits combined every Benefit Plan Year)*. Note: There is no visit limit for Physical, Occupational and Speech Therapy for Autism Spectrum Disorder only.	
- Facility/Hospital based	After Deductible, Plan pays 70%
- Office based or free-standing	You pay $50 copay/visit
Cardiac rehabilitation *(36 visits every Benefit Plan Year)*	
- Facility/Hospital based	After Deductible, Plan pays 70%
- Office based or free-standing	You pay $50 copay/visit
Autism spectrum disorder	
- Physical Therapy/ Speech Therapy/ Occupational Therapy - Facility/Hospital Based	After Deductible, Plan pays 70%
- Office based or free-standing	You pay $30 copay/visit
- Behavioral Therapy	You pay $30 copay/visit
- Applied Behavioral Analysis (ABA)	You pay $30 copay/visit
Laboratory services	
- Facility/Hospital based	After Deductible, Plan pays 70%
- Office based or free-standing lab	You pay $30 copay/visit
Other Diagnostic Services X-rays/MRIs/CT scans/PET scans/MRAs/mammography etc.	
- Facility/Hospital based	After Deductible, Plan pays 70%
- Office based	After Deductible, Plan pays 70%
Durable Medical Equipment	After Deductible, Plan pays 70%
Home Health Care Services *(60 visits every Benefit Plan Year/ not to exceed 4 hrs. per visit)*	After Deductible, Plan pays 70%
Private Duty Nursing *(70 shifts every Benefit Plan Year/ one shift equals up to 8 hrs.)*	After Deductible, Plan pays 70%
Home infusion/IV Therapy	
- Facility/Hospital based	See All Other Outpatient Care
- Office based	See Office Visit Benefit
- Home based	See Home Health Care Benefit
Hospice care	
- Facility/Hospital based	After Deductible, Plan pays 70%
- Home based	After Deductible, Plan pays 70%
Spinal Manipulation/Chiropractic Care *(Covered age 18 and older only - 30 visit maximum every Benefit Plan Year)*	You pay $50 copay/visit

Fertility services	Refer to Core SPD for coverage details and limitations/exclusions
Orthotics/Prosthetics	After Deductible, Plan pays 70%
Wigs ***(Covered one every Benefit Plan Year)***	After Deductible, Plan pays 70%
Podiatry services ***(Routine Services are not covered)***	You pay $50 copay/visit
Mental Health & Substance Use Disorder Services	
Inpatient/ Residential Treatment Facility	
- Facility/Hospital based	$500 copay per admission, after Deductible, then Plan pays 70%
- Physician/professional charges	After Deductible, Plan pays 100%
Outpatient	
- Office based	You pay $30 copay/visit
- All other Outpatient ***(includes: Partial Hospitalization treatment, intensive outpatient program, skilled behavioral health services, electro-convulsive therapy (ECT), transcranial magnetic stimulation (TMS), psychological and neuropsychological testing, 23 hour observation, peer counseling support by a peer support specialist, outpatient and ambulatory detoxification)***	After Deductible, Plan pays 70%
Hearing services	
Hearing exams	You pay $50 copay/visit
Hearing aids	After Deductible, Plan pays 70%
Prescription & vision services	
Adult routine vision care ***(1 routine exam In-Network every Plan Benefit Plan Year)***	You pay $50 copay/visit
Pediatric routine vision care (up to age 19) ***(1 routine exam In-Network every Plan Benefit Plan Year)***	Plan pays 100%
Pediatric contact lenses or pediatric optical lenses for glasses and treatments ***(contact lenses or lenses for glasses every Plan Benefit Plan Year, but not both in a Plan Benefit Plan Year, for up to age 19)***	Plan pays 100% up to $125 maximum per year
Non routine vision care (adult & pediatric)	You pay $50 copay/visit
Prescription Drugs - Express Scripts ***Must use participating pharmacy***	Refer to Prescription Benefit Plan Summary

PRESCRIPTION BENEFIT PLAN SUMMARY

Members Health Plan NJ offers its members comprehensive pharmacy coverage through Express Scripts.

The following Prescription Drug Benefit Section applies for all Plans that have elected Prescription Coverage. Please contact your Employer or refer to your ID Card to see which Rx Option you are enrolled in.

PRESCRIPTION PLAN OPTIONS
RX Plan 1 – Only available with Medical Plans (A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30-day supply): $15 - Generic, $35 - Preferred Brand, $50 - Non Preferred Brand Maintenance and Home Delivery (90-day supply)*: $35 - Generic, $82.50 - Preferred Brand, $120 - Non Preferred Brand
RX Plan 2 - Only available with Medical Plans (A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30-day supply): $30 - Generic, $50 - Preferred Brand, $80 - Non Preferred Brand Maintenance and Home Delivery (90-day supply)*: $70 - Generic, $120 - Preferred Brand, $195 - Non Preferred Brand
RX Plan 3 - Only available with Medical Plans (A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z)
Retail (30-day supply): Generic: - $15 copay / Brand - 50% copay (Min of $25 /Max of $500) *(50% copay applies to the contracted rate)* Maintenance and Home Delivery (90-day supply)*: Generic: - $37.50 copay / Brand - 50% copay (Min of $62.50 /Max of $1,250) *(50% copay applies to the contracted rate)*
RX Plan 4 - ONLY Available with Plans N, R, S, W (This RX Plan would be considered an IRS/HSA compatible RX Plan.)
MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES Retail (30-day supply): $15 - Generic, $35 - Preferred Brand, $50 - Non Preferred Brand Maintenance and Home Delivery (90-day supply)*: $35 - Generic, $82.50 - Preferred Brand, $120 - Non Preferred Brand
RX Plan 5 - ONLY Available with Plans N, R, S, W (This RX Plan would be considered an IRS/HSA compatible RX Plan.)
MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES Retail (30-day supply): Generic: - $15 copay after Deductible / Brand - 50% copay after Deductible (Min of $25 /Max of $500) *(50% copay applies to the contracted rate)* Maintenance and Home Delivery (90-day supply)*: Generic: - $37.50 copay after Deductible / Brand - 50% copay after Deductible (Min of $62.50 /Max of $1,250) *(50% copay applies to the contracted rate)*
RX Plan 6 - Only available with Medical Plans (A, B, D, F, G, H, J, K, L, M, O, P, T, U, V, X, Y, Z) (If No RX is selected, medical rates will increase 3%)
No RX Coverage

You can select one (1) or more Rx Options per each Medical Plan Option you select

All MHPNJ Prescription Programs have cost saving measures in place to ensure that both our Members and our Plan save the most on covered prescriptions.

***Maintenance Medication (90-day supply) and Home Delivery Program – Walgreens Smart 90 Program**. You'll pay more for Your long-term Drugs (such as those used to treat high blood pressure or high cholesterol) unless You use a Walgreens Pharmacy or order Your prescriptions through the mail by using the Mail Order Pharmacy. The first two times that You purchase a long-term drug at a participating retail Pharmacy, You'll pay Your retail co-payment. After the second purchase, You'll pay a higher cost if You continue to purchase maintenance medications in a 90-day supply at any retail pharmacy except Walgreens Pharmacy.

• **Save by using Generics** - The Plan has a program in place to automatically fill your prescription with the low cost generic alternative to save both you and the Plan. If you request a brand-name medication when a generic equivalent is available, you will pay the applicable co-payment, plus the difference in cost between the brand and the generic.

• **SaveonSP Program**- The Plan is partnering with Express-Scripts' program: SaveonSP, a specialty pharmacy Copayment assistance program. By participating in this program, select specialty medications will be free of charge ($0). Your prescriptions will still be filled through Accredo, your existing specialty mail pharmacy. Certain specialty pharmacy drugs are considered non-essential health benefits under the Plan and the cost of such drugs will not be applied toward satisfying the participant's Maximum Out-of-Pocket (drug list can be found at www.membershealthplannj.com under pharmacy); although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant; and Copayments for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded Copayment assistance. The program currently targets 150+ specialty drugs in 10 therapy classes: Asthma & Allergy, Blood Cell Deficiency, Cystic Fibrosis, Hemophilia, Hepatitis C, Hereditary Angioedema, Inflammatory, Oncology, Multiple Sclerosis, Pulmonary Arterial Hypertension. Letters will be sent to impacted members on non-HSA plans to voluntarily enroll those individuals in the program. To enroll, simply call SaveonSP at 1-800-683-1074. If You choose not to participate, You will be responsible for an increased Copayment for select medications. Keep in mind that the Copayment will not count towards Your Deductible or Maximum Out-of-Pocket.

NOTES

Members HealthPlan NJ