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 P - HIGH DEDUCTIBLE 70% PLAN
SCHEDULE OF BENEFITS
No Referrals are Required to see a Specialist

	In-Network	Out-of-Network
Network Providers	Aetna - Choice POS II	
Benefit Plan Year	Calendar Year	Calendar Year
Benefit Plan Year	Calendar Year	Calendar Year
Deductible	$5,000/Individual; $10,000/Family (Embedded)	$5,000/Individual; $10,000/Family (Embedded)
Coinsurance	Plan Pays 70%	Plan Pays 50%
Maximum Out-of-Pocket (MOOP)	$6,850/Individual; $13,700/Family (Embedded)	$13,700/Individual; $27,400/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	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	(1) For all Out-of-Network elective and Non-Emergent Services, the Plan will pay the Plan's Allowable Charges which will be based on 110% for Professional services and 140% for Facilities of current year Medicare/RBRVS. Refer to definition of Plan's Allowable Charges in Summary Plan Description.	
Physician office visits		
Primary Care Provider office visit	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Specialist Physician office visit	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Walk In Clinic	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Gynecological care		
- Routine (Preventive)	Plan pays 100%	Routine care not covered
- Non-routine	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Routine pre-natal care	You pay $50 Copay (initial visit only)	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Consultations/second opinions	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)
Office based Surgery	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges (1)

Allergy injections and allergy test **- With office visit** **- Without office visit**	 You pay $50 Copay/visit After Deductible, Plan pays 70%	 After Deductible, Plan pays 50% of Plan's Allowable Charges [1] After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Preventive Care (wellness office visit)	Plan pays 100%	Routine care not covered.
Preventive Care/screenings	Plan pays 100%	Routine care not covered.
Influenza vaccine	Plan pays 100%	Routine care not covered.
	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	You pay $50 Copay/visit
Emergency room services	After Deductible, Plan pays 70%	After Deductible, Plan pays 70%
Emergency Admission		
Authorization required within 48hrs or as soon as reasonably possible. **- Facility/Hospital charges** **- Physician/professional charges**	 After Deductible, Plan pays 70% After Deductible, Plan pays 70%	 After Deductible, 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%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Hospital and surgical care		
Inpatient care ***Semi-private hospitalization*** **- Facility/Hospital charges** **- Ancillary/diagnostic charges** **- Physician/professional charges**	 After Deductible, Plan pays 70% After Deductible, Plan pays 70% After Deductible, Plan pays 70%	 After Deductible, Plan pays 50% of Plan's Allowable Charges [1] After Deductible, Plan pays 50% of Plan's Allowable Charges [1] After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
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)***	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
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%	 After Deductible, Plan pays 50% of Plan's Allowable Charges [1] After Deductible, Plan pays 50% of Plan's Allowable Charges [1] After Deductible, Plan pays 50% of Plan's Allowable Charges [1]

All other Outpatient Care		
- Facility/Hospital charges	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Ancillary/diagnostic charges	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Physician/professional charges	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Pre-admission testing	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
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.**	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
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%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Office based or free-standing	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Cardiac rehabilitation ***(36 visits every Benefit Plan Year)***		
- Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Office based or free-standing	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Autism spectrum disorder		
- Physical Therapy/ Speech Therapy/Occupational Therapy - Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Office based or free-standing	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Behavioral Therapy	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Applied Behavioral Analysis (ABA)	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]

Laboratory services		
- Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Office based or free-standing lab	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Other Diagnostic Services X-rays/MRIs/CT scans/PET scans/MRAs/mammography etc.		
- Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Office based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Durable Medical Equipment	After Deductible, Plan pays 70%	Not Covered
Home Health Care Services ***(60 visits every Benefit Plan Year/ not to exceed 4 hrs. per visit)***	After Deductible, Plan pays 70%	Not Covered
Private Duty Nursing ***(70 shifts every Benefit Plan Year/ one shift equals up to 8 hrs.)***	After Deductible, Plan pays 70%	Not Covered
Home infusion/IV Therapy		
- Facility/Hospital based	See All Other Outpatient Care	Not Covered
- Office based	See Office Visit Benefit	Not Covered
- Home based	See Home Health Care Benefit	Not Covered
Hospice Care		
- Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Home based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Spinal Manipulation/Chiropractic Services ***(Covered age 18 and older only - 30 visit maximum every Benefit Plan Year)***	You pay $50 Copay/visit	Not Covered
Fertility services	Refer to Core SPD for coverage details and limitations/exclusions	
Orthotics/Prosthetics	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Wigs ***(Covered one every Benefit Plan Year)***	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Podiatry services ***(Routine Services are not covered)***	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
Mental Health & Substance Use Disorder Services		
Inpatient/ Residential Treatment Facility		
- Facility/Hospital based	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]
- Physician/professional charges	After Deductible, Plan pays 70%	After Deductible, Plan pays 50% of Plan's Allowable Charges [1]

Outpatient **- Office based**	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [(1)]
- 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%	After Deductible, Plan pays 50% of Plan's Allowable Charges [(1)]
Hearing services		
Hearing exams **Hearing aids** ***(1 per 24 months per ear to age 16 every Plan Benefit Year)***	You pay $50 Copay/visit After Deductible, Plan pays 70%	Not Covered After Deductible, Plan pays 50% of Plan's Allowable Charges [(1)]
Prescription & vision services		
Adult routine vision care ***(1 routine exam In-Network every Plan Benefit Plan Year)***	You pay $50 Copay/visit	Not Covered
Pediatric routine vision care (up to age 19) ***(1 routine exam In-Network every Plan Benefit Plan Year)***	Plan pays 100%	Not Covered
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	Plan pays 100% up to $125 maximum per year
Non routine vision care (adult & pediatric)	You pay $50 Copay/visit	After Deductible, Plan pays 50% of Plan's Allowable Charges [(1)]
Prescription Drugs - Express Scripts ***Must use participating Pharmacy***	Refer to Prescription Benefit Plan Summary	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.