PLAN DOCUMENT
FOR THE
STUDENT HEALTH BENEFITS PLAN (SHBP)

EFFECTIVE DATE: SEPTEMBER 1, 2023

This document is pending annual review and approval by the US Department of Health and Human Services, Centers for Medicaid and Medicare Services, for recognition that the SHBP provides Minimum Essential Coverage

For the most current information regarding the SHBP, notices, and general information, students should refer to the Student Health Program web site:

https://www.ptsem.edu/admissions/entering-students/enrollment

PRINCETON THEOLOGICAL SEMINARY

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Abbreviations and terms both capitalized and italicized are defined in Section XVII: Definitions (e.g., *Urgent Care*). Capitalized terms without italics are either major or subsection headings in this Plan Document or are terms used to identify organizations or individuals in Section III: General Information (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics with no specific section referral, see the Table of Contents and/or Section III: General Information.

THIS INSTRUMENT, established by Princeton Theological Seminary (hereinafter the Seminary or *Plan Sponsor*), sets forth the Princeton Theological Seminary Student Health Benefits Plan (hereinafter the SHBP).

A. Establishment of the SHBP. The *Plan Sponsor* hereby sets forth its student group health plan under the following terms and conditions.

(1) The *Plan Sponsor* provides the SHBP for the sole purpose of providing health care benefits to the *Students* covered by the program. SHBP reserve funds are encumbered for the sole purpose of operating the SHBP.

(2) In the event there are surplus reserve funds upon termination of the SHBP, these funds will be used exclusively to provide health care services and/or health education services for the *Plan Sponsor Student* population.

(3) SHBP claims/operating funds and SHBP reserve funds earn interest income and are not commingled with the *Plan Sponsor*'s other accounts.

(4) Benefits are administered exclusively based on the provisions of this Plan Document. There are no unpublished Plan provisions.

(5) Extra-contractual benefits may be provided only to the extent that the Plan Administrator determines that such benefits are *Medically Necessary* and result in either (1) improved quality of care for the *Covered Person* with no substantive difference in the amount of benefit payments that would otherwise be provided by the SHBP, or (2) cost savings for the SHBP. Upon recommendation of the Claims Administrator, any extra-contractual benefits must be reviewed and approved by the Plan Administrator.

B. Effective. The SHBP for the 2023-2024 *Plan Year*, as described herein, is revised effective **September 1, 2023**, originally effective September 1, 2005.

C. General Provisions. The SHBP is subject to all of the conditions and provisions set forth in this document and subsequent amendments, which are made a part of this Plan Document.

IN WITNESS WHEREOF, Princeton Theological Seminary has caused the SHBP to be executed by its duly-authorized representative.

Princeton Theological Seminary

By: _____

Date _____ Authorized Signature

Title _____ Printed Name

Princeton Theological Seminary has prepared this document to help you understand your medical and prescription drug benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if such services are *Medically Necessary* and your *Physician* or other *Health Care Provider* recommends them.

When you visit a health care provider to receive services, make sure to note that the provider network is CIGNA (please refer to your identification card). Some providers may not recognize the SHBP and could inadvertently conclude that they are not in-network with the SHBP. Making reference to CIGNA should help avoid confusion with providers.

Abbreviations and terms both capitalized and italicized are defined in Section XVIII: Definitions (e.g., *Urgent Care*). Capitalized terms without italics are either major or subsection headings in this Plan Document or are terms used to identify organizations or individuals in Section III: General Information (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics with no specific Section referral, see the Table of Contents and/or Section III: General Information.

For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international *Student*s and their covered dependents, such SHBP benefits are provided only to the extent that they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

As used in this document, the word *year* refers to the *Plan Year*, which is the 12-month period beginning September 1 and ending August 31. Maximums and deductibles accumulate during the *Plan Year*. The word *Lifetime* as used in this document refers to the period of time you or your eligible dependents participate in the SHBP or any other *Plan Sponsor*ed by Princeton Theological Seminary for its students and/or their eligible dependents.

Your benefits under the SHBP are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your *Health Care Provider* recommends them.

You can minimize your out-of-pocket expenses by using *In-Network Providers*.

If you have questions about any of your coverage, please contact the SHBP's Claims Administrator: Wellfleet, 877-657-5030. By working together, we can help contain medical expenses. Please make note of the following provisions.

(1) Preferred Provider Networks

The chosen Preferred Provider Network is a group of *Health Care Providers* and *Hospitals* who have agreed to accept a negotiated fee for their services. Preferred Provider Networks may be used by *Covered Persons* to provide most of the Medical Benefits described in Section IX of this Plan Document. As a *Covered Person* in the SHBP, you maintain the freedom to choose participating or non-participating *Health Care Providers*. Please visit: www.Cigna.com for a listing of participating *Health Care Provider*.

When you choose a participating *Health Care Provider* or *Hospital*, the SHBP contains many advantages because:

(a) you usually pay less out-of-pocket for health care services;

(b) you may change your *Health Care Provider(s)* and/or *Hospital* at any time, because you are not required to designate a primary care *Health Care Provider*;

(c) your participating *Health Care Provider(s)* and/or *Hospital* will file claims directly, so you do not have to wait for claim reimbursement; and

(d) you are not responsible for charges over the negotiated fees allowed by the applicable network for the Schedule of Medical Benefits provided under Section VI of this Plan Document, but you are responsible for the applicable deductible, copayment, and/or coinsurance amounts.

All services must be *Medically Necessary* and must be *Covered Expense/Service* that is not limited or excluded in this Plan Document.

(2) Required Prior Notification of Hospital Admission Requirements – Elective and Emergency Admissions

Prior to any elective admission to a hospital, hospice facility, or skilled nursing facility, you must notify Wellfleet by calling their toll-free number 877-657-5030. You must also call within forty-eight (48) hours (two (2) working days) following any emergency admission. When you call, it will be necessary to provide the subscriber's name, the patient's name, the name of the physician and hospital or facility, the reason for the hospitalization, and any other information needed to complete the process.

If you do not follow the Pre-Admission Certification Requirement Prior Notification Procedure described above, the plan will cover only 50% of hospital charges. This is in addition to any applicable deductible amount that you are required to pay. The penalty for failing to follow the Prior Notification Requirement procedures does not count toward your out-of-pocket maximum.

(3) Required Benefits

The SHBP complies fully with the benefit requirements, appeals procedures, and certain other provisions of the regulations issued by the U.S. Department of Health and Human Services for fully insured student health insurance programs under the Patient Protection and Affordable Care Act (PPACA). You are encouraged to review the preventive care benefits included in the program and the new appeals procedure. Refer respectively to Sections VIII: Required Benefits, and Section XVI, Procedures/Statement of Rights.

The SHBP also full complies with the benefit requirements specified for the State of New Jersey's Essential Health Benefits Benchmark Plan.

Plan Name	Student Health Benefits Plan (SHBP).
Type of Plan	Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a partially self-funded basis.
Effective	**Revised effective September 1, 2023** **Originally effective September 1, 2005.**
Plan Sponsor	Princeton Theological Seminary 64 Mercer Street, Princeton, New Jersey 08542-0803
Group Number	ST2262SH
Plan Administrator	Director of Student Financial Services Princeton Theological Seminary 64 Mercer Street P.O. Box 821 Princeton, NJ 08542-0803 michael.livio@ptsem.edu 609-497-7781
Claims Administrator (refer to Section XVI, Procedures/Statement of Rights, for claims submission instructions)	Wellfleet Group, LLC P.O. Box 15369 Springfield, MA 01115 www.WellfleetStudent.com 877-657-5030
In-Network Providers	CIGNA PPO Link to search for In-Network Providers: www.Cigna.com. *In-Network Providers* directly contracted by the *Plan Sponsor* for the SHBP: • Penn Medicine Princeton Health • Trinity Counseling Service • Specialty Counseling Network
Prescription Benefit Administrator	Wellfleet Rx/ESI www.WellfleetRx.com/Student/Pharmacy-Network 877-640-7940
Case Management Services	CIGNA
Medical Evacuation and Repatriation Provider	Amwins SMIC www.amwins.com

Agent for Service of Legal Process	Secretary of the Seminary Princeton Theological Seminary 64 Mercer Street P.O. Box 821 Princeton, NJ 08542-0803
Termination and/or Modification of SHBP	The *Plan Sponsor* may terminate the SHBP at the end of any *Plan Year* or change the provisions of the SHBP at any time by a written amendment signed by a duly-authorized officer of the *Plan Sponsor*. The Plan Administrator will notify all Covered Persons of any amendment modifying the material terms of the SHBP no less than 60 days prior to the effective date of the amendment. The consent of any *Covered Person* is not required to terminate or change the SHBP. The SHBP also provides telemedicine benefits, in state jurisdictions where legally permissible, on the same basis as other benefits provided by the SHBP.

Student Eligibility

You are eligible to participate in the SHBP if you qualify as one of the following:

- A full-time or part-time student, who is subject to the Seminary's insurance requirement, and who is enrolled at Princeton Theological Seminary if enrollment occurs pursuant to the *Annual Open Enrollment Period* requirements for the SHBP or other SHBP open enrollment periods for students who are not enrolled for the full academic year.

- Doctoral Teaching Fellows at Princeton Theological Seminary.

- An international student, regardless of degree seeking status or credit hour enrollment, enrolled at Princeton Theological Seminary.

Dependent Eligibility

Your eligible dependents may participate in the SHBP, provided you are also currently enrolled. Eligible dependents include:

- Your lawful spouse as defined by applicable state law;

- A child who has not attained age 26.

- A *Physically or Mentally Disabled Child* of any age, provided the disability began before he or she has attained age 26 and while covered under the SHBP. Coverage may continue for as long as the child remains *Physically or Mentally Disabled*, unmarried and wholly dependent upon you for financial support (in accordance with Internal Revenue Service dependent guidelines). The SHBP may require you at any time to submit a *Physician's* statement certifying the child's *Physical or Mental Disability.*

For purposes of the SHBP, child means:

- A child who, before reaching the age of 18, was either adopted by you or placed in your home for adoption;

- A stepchild;

- A foster child;

- Your natural child, including any child for whom you are required to provide coverage under a court order.

If you and your spouse are both students, only one of you may cover a dependent child. In addition, you may not participate in the SHBP as both a student and as a dependent at the same time.

Student Enrollment

You will be billed for the SHBP unless you submit an approved waiver of coverage within the time prescribed by Princeton Theological Seminary. To activate your coverage, you must complete an enrollment form for the SHBP each academic year. Your coverage will become effective as stated below under the sub-section of When Coverage Begins.

Dependent Enrollment

You must enroll your eligible dependents within 31 days of when you enroll at Princeton Theological Seminary. If you do not have any eligible dependents at the time of initial enrollment, but acquire eligible dependents at a later date, you must enroll the dependent(s) within 31 days of the date you acquire them. You may also enroll your eligible dependents during the *Annual Open Enrollment Period* in September of each year. Your coverage will become effective as described in the Section of this Plan Document entitled When Coverage Begins.

Your newborn child is automatically covered at birth for 31 days. For coverage to continue beyond 31 days, you must notify the *Plan Administrator* (i.e., Office of Student Financial Services at Princeton Theological Seminary) of the birth and pay any required contribution during the 31-day period following the birth. If you fail to do so, coverage will terminate at the end of 31 days following your child's birth. Submission of claims for maternity expenses does not qualify as notification to the *Plan Administrator*.

The 31-day automatic coverage provision also applies to the adoption of a child. Coverage begins when the adoption process is finalized, and the adoption is effective.

Late Enrollments

If you waived coverage under the SHBP for yourself or your dependents because you or they had coverage under an employer-sponsored group health plan, and that coverage ends for any reason other than non-payment of premium, you may enroll yourself and/or your dependents for coverage, provided you do so within 31 days of the date coverage under the other plan ends.

If you do not enroll within the 31-day period, you will not be allowed to enroll in this plan until the next *Annual Open Enrollment Period*.

There is a pro-rated fee schedule for late enrollments. Late enrollments are subject to all limitations, provisions, and requirements of the SHBP.

When Coverage Begins

Your coverage begins on the earlier of September 1 or the date you are required to be at Princeton Theological Seminary for a Seminary-sponsored activity. In no event will your coverage begin prior to August 1. Coverage for your dependents begins the later of the date your coverage begins or the first day a dependent is legally acquired, if the dependent is properly enrolled. In the case of a late enrollment, coverage begins on the date coverage under the other health plan ends.

The effective date for Doctoral Teaching Fellows will be the date designated by the Seminary. The date may be set to provide coverage not more than 60 days prior to the date the Doctoral Teaching Fellow will arrive at the Seminary.

For students and their dependents who first enroll at the Seminary for the summer session that typically begins on or about July 1, these students and their dependents will be eligible for the SHBP for the remaining two months of coverage under the *Plan Year* then effect, subject to payment of the appropriate SHBP costs. Other students and dependents who enroll in academic programs that are not for the full academic year will also be eligible for remaining weeks of coverage in the month their programs begin, subject to appropriate SHBP costs.

When Coverage Ends

Your coverage will end for you and your covered dependents on the earliest of the following dates:

- August 31st, if you waive coverage for the next *Plan Year* or you or your dependents are no longer eligible to participate in the SHBP.
- On the day the SHBP terminates.
- On the day in which the *Covered Person* dies.
- On the day an international *Student* withdraws from the Seminary or the day an international *Student* receives an Approved Medical Withdrawal from the Seminary and leaves the United States.
- The first date of class for the spring semester for students who complete their degree requirements or otherwise withdraw from the Seminary during the fall semester or at the end of the fall semester. Coverage will also end for students who request withdrawal from the SHBP based on acquiring health insurance during the fall semester that meets the Seminary's requirements. No other provisions for withdrawal from the SHBP are available, except as specifically provided in this Plan Document.
- You may apply for cancellation of your student coverage for the spring semester (prior to the end of the fall semester coverage period) if you provide evidence that you have attained coverage under an employer-sponsored group health insurance plan that meets all of the Seminary's requirements for health insurance coverage. Cancellation of coverage at any other time is not permitted, except as specifically provided for Covered Persons who enter into the armed services of any country.
- For students who acquire other health insurance that meets the Seminary's requirements, a prorated refund of the SHBP cost will be provided. The refund will be calculated on a monthly basis rather than the day the student acquires coverage.
- Coverage for your dependents ends on the earliest of the following dates:
  - The date your coverage ends.
  - The end of the *Plan Year* for a spouse who is divorced or separated from a *Covered Student* during the *Plan Year.*
  - The date you cancel your dependent's coverage. Dependent coverage may be canceled for the spring semester if the student waives the right for payment of future claims for the dependent.

CONVERSION PRIVILEGE OR EXTENSION OF ELIGIBILITY Section V

Except for provided in Section IV under Approved Medical Withdrawal, there is no extension of eligibility or extension of benefits under the SHBP. The Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA) does not apply to the SHBP because there is no employer and employee relationship between Princeton Theological Seminary and its students covered under the SHBP.

There is no Conversion Privilege under the Student Health Benefits Plan provided by Princeton Theological Seminary.

This schedule applies to medical benefits only. Refer to Section VII for Prescription Benefits.

Benefit Description	Coinsurance Amount (What the SHBP Pays)			
	In-Network			
	In Princeton Area • Hospital: Princeton Health* • Trinity Counseling Service* • Specialty Counseling Network* * Under direct contract to the Seminary.			
	Providers in Princeton Area Other than above: Provider Network: CIGNA PPO Refer also to the definition for *In-Network Providers* for benefit provisions when an *In-Network Provider* is not available.	**Outside the Princeton Area** Provider Network: CIGNA PPO	**Out-of-Network**	**Comments**
Aggregate Plan Year Deductible Individual Family	$0 $0 *There is no deductible for in-network care. If a Copayment is not specified for a specific service, the plan provides benefits at 80% of the Preferred Allowance.*		$250 $750	*Unless otherwise specified, all services are subject to the Aggregate Plan Year Deductible.*
Plan Year Out-of-Pocket Maximum Individual Family The *Plan Year* out-of-pocket maximums are combined for all categories of coverage.	$3,500 $7,000		$7,750 $23,250	Includes all other maximums and prescription drug benefits.
Lifetime Individual Maximum for All Benefits	Unlimited			
Preventive Services			Out-of-Network	
Preventive care services are covered in compliance with the Patient Protection and Affordable Care Act (PPACA) Certain other preventive care services are	$0 *Copayment* $0 *Coinsurance*	$0 *Copayment* $0 *Coinsurance*.	Not Covered	Refer to Section VIII, Required Benefits

provided in addition to the mandated coverage under the PPACA. Refer to other provisions of this Schedule of Medical Benefits for copayment and coinsurance requirements.				
Required Pediatric Dental Benefits	Refer to Section VIII, Required Benefits		Not Covered	
Medical Services			Out-of-Network	
Medical Office Visits (includes visits to Registered Dieticians) (*Sickness, Injury*, or Preventive Services for Children)	$35 copayment per visit and then 100% of *Preferred Allowance* Ancillary expenses, including surgical procedures, laboratory and X-rays that are billed by the *Physician's* office are also covered at 100% of the *Preferred Allowance*.	Same as *Princeton Area In-Network* Benefits	70% of Reasonable *and Customary* allowance	Refer to Required Benefits for Wellness benefits for children. This *Copayment* may not be used to satisfy the *Aggregate Plan Year Deductible*. Coverage is provided for telemedicine services when provided in state jurisdictions where telemedicine is legally permissible.
Surgeon's Fees	$100 *Copayment* per surgical procedures and then 80% of *Preferred Allowance.* *The copayment does not apply to procedures performed under the Medical Office Visits benefit.* .	Same as *Princeton Area In-Network* Benefits	70% of Reasonable *and Customary* allowance	Multiple *Copayments* are not charged for multiple surgeries performed during the same operating session.
Emergency Room Services	$100 per visit *Copayment*, then 100% of *Preferred Allowance* for expenses incurred at Emergency Department of Penn Medicine Princeton Health. This benefit includes all charges incurred in the Emergency Department, including *Physician* charges, and ancillary services for laboratory and X-ray.	Same as *Princeton Area In-Network* Benefits	Same as *Princeton Area In-Network* Benefits, subject to *Reasonable and Customary* allowance	This *Copayment* may not be used to satisfy the *Aggregate Plan Year Deductible*. Covered only for an *Emergency Medical Condition.*

Urgent, Non-Routine, After Hours Care	Covered Same as Medical Office Visits		70% of Reasonable *and Customary* allowance	Urgent care services at may be covered under the Medical Office Visit benefit, but there will be no greater reimbursement for urgent care services.
Inpatient Hospital Services	$300 per *Hospital* admission *Copayment* and 80% o*f Preferred Allowance*		70% of Reasonable *and Customary* allowance	*Physician* visits on an *Inpatient* basis are covered at 80% of the *Preferred Allowance* for *In-Network* care (not subject to visit copayment) **Hospital pre-certification is required** (refer to Required Prior Notification of Hospital Admission Requirements – Elective and Emergency Admissions under Section II, Introduction).
Outpatient Hospital or Facility Services, including surgical centers.	80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	Copayments may apply to certain services/procedures for In-Network Providers.
Maternity Services Complications of Pregnancy benefits are provided on the same basis as any other *Sickness* and are paid as a separate and distinct condition from Pregnancy.	Benefits are provided on the same basis as any other *Sickness* or temporary disability.		Benefits are provided on the same basis as any other *Sickness* or temporary disability.	
Laboratory and X-ray	$0 *Copayment* and 80% of *Preferred Allowance*		70% of Reasonable *and Customary* allowance	
Diagnostic Imaging and Scans	$200 *Copayment* for scans and imaging for diagnostic testing (e.g., MRI, PET, CAT, etc.) and 80% of *Preferred Allowance*		70% of Reasonable *and Customary* allowance	
Ambulance (Covered only for ground transportation).	Not covered *(there are no in-network providers in the Princeton area)*	$100 *Copayment* per trip and then 80% of Preferred Allowance	70% of Reasonable *and Customary* allowance	Refer to the separate emergency travel and assistance coverage for *Covered Persons* for air ambulance benefits.
Skilled Nursing Facility	$0 *Copayment* and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	Subject to *Medical Necessity* determination by the SHBP *Claims Administrator.*
Private Duty Nursing (60 visits per *Plan Year*)	$0 *Copayment* and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	Subject to *Medical Necessity* determination by the SHBP *Claims Administrator.*
Physical Therapy (up to 30 visits per *Plan Year*)	$35 *Copayment* per visit when services are provided at Penn Medicine Princeton Health and 80% of *Preferred Allowance*	$50 *Copayment* per visit and 80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	

Occupational, Speech Therapy, Cognitive Therapy, Respiration Therapy, and Pain Management.	$35 *Copayment* and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Home Health Care Up to a combined maximum benefit of 60 days per *Plan Year.*	$0 *Copayment* and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Hospice Facility or Home Hospice	$0 copayment and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Habilitative Services (not otherwise specified)	80% of *Preferred Allowance* *(copayments may apply to certain visit/procedures)*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Durable Medical Equipment	$0 copayment and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Chemotherapy and Radiation Treatments	$0 copayment and 80% of *Preferred Allowance*	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	
Dental Care Due to Accidental Injury	$0 copayment and 80% of the Reasonable and Customary allowance.			
Required Benefits Refer to Section XI, Required Benefits. • Testing for Deficit Disorder, Reading or Learning Disorders, and Developmental Dyslexia.	80% of *Preferred Allowance* *(copayments may apply to certain visit/procedures)* Testing for Deficit Disorder, Reading or Learning Disorders, and Developmental Dyslexia, is limited to a maximum of $300 per assessment and report.	80% of *Preferred Allowance*	70% of Reasonable *and Customary* allowance	Refer to Section XI, Required Benefits.

**In-Network* benefits are reduced by the amount of any Out-of-Network benefits that are utilized.

For more information about your prescription drug benefits, refer to the Section VII, Prescription Benefits.

Benefit Description	Coinsurance Amount (What the SHBP Pays)			
Inpatient Mental/Nervous Disorder and Substance Abuse Treatment Services	Benefits are provided on the same basis as any other *Sickness*.			
Outpatient Partial Hospitalization Participation in intensive outpatient program for a Mental/Nervous Disorder or Alcohol/ Substance Abuse Care.	$0 Copayment Covered at 100% of Preferred Allowance		Covered on the same basis as any other Outpatient service or supply.	
Outpatient Mental/Nervous Disorder and Substance Abuse Treatment Services	Benefits are provided on the same basis as any other Sickness except that visit Copayments will be charged at $15 for services provided by Trinity Counseling Service, after Student Administrative Health Fee Benefits are first paid. For all other providers, there is a $25 Copayment for outpatient Mental/Nervous Disorder counseling. The Copayment is $10 per group session for support, psychotherapy and skills training groups provided by either Trinity Counseling Service or Specialty Counseling Network providers.			*In-Network Providers* in the *Princeton Area* include Trinity Counseling Service and the Specialty Counseling Network. Referral not required outside of the *Princeton Area*. This benefit includes coverage for pre-marital counseling
Spiritual Direction This is a wellness/ educational support benefit and is not provided as a mental health care benefit.	*Copayment*s for Individual Spiritual Direction are $10 per visit for services at the *Provider's* Office and $15 per visit if provided on campus up to a maximum *Plan Year* benefit of 12 sessions. *Copayment*s for Spiritual Direction, Psychotherapy, and Support Groups are $10 per session (groups with outside facilitators).	Not Covered	Not Covered	Group benefits are administered internally by Princeton Theological Seminary
Support and Psychotherapy Groups Provided by Counseling at Princeton Theological Seminary (or by Specialty Counseling Network providers), or Trinity Counseling Services.	$10 *Copayment* Per Group Session	Not Covered	Not Covered	

Benefit Description	Prescription Drug Benefits		Comments
Annual Plan Year Deductible	A one-time Annual Plan Year Deductible of $50.00 must be satisfied before prescription drug benefits will be paid under the In-network or Out-of-Network prescription drug coverage.		
Copayments	Copayments per 30-day supply 100% coverage following satisfaction of *Copayment* requirements.		Special arrangements can be made for extended supplies for students traveling abroad. (Contact the *Claims Administrator*).
	In-Network: Wellfleet Rx/ESI Participating Pharmacies. **Formulary:** **https://wellfleetrx.com/students/formularies/)**	**Out-of-Network** (Pharmacies that do not participate with Wellfleet RX)	
Zero Cost Prescriptions *(not subject to Deductible)*	$0 copayment Wellfleet Rx Student Formulary offers 40+ antibiotics, dermatology, and behavioral health medications at no copay. Refer to the "Zero Cost Drugs" section of the Student Formulary for the full list of medications covered under this program.	N/A	
Generic	$15 *Copayment* $0 *Copayment* for prescription contraception mandated by Required Care.	Same *Copayment* schedule for *In-Network* Pharmacies – the maximum allowance is the lesser of the *Wellfleet Rx Maximum Allowable Cost* under the Wellfleet Rx fee schedule or the *Reasonable and Customary Charge* allowance.	
Preferred Brand Name	$25 *Copayment* $0 *Copayment* for *Medically Necessary* prescription contraception mandated by Required Care.		
Non-Preferred Brand Name	$40 *Copayment*		
Mail Order Copayments	Copayments per 90-day supply. 100% coverage following satisfaction of Copayment requirements		
Mail Order	• Generic: $30 *Copayment* • Preferred Brand Name: $50 *Copayment* • Non-Preferred Brand Name: $80 *Copayment*	N/A	Refer to Section X, Prescription Drugs, for instructions for using the Mail Order program with Wellfleet Rx

Many medications have manufacturer programs which will financially assist patients in the purchase of the medication. The SHBP requires that if a financial assistance program is available, you must participate in the financial assistance program provided by the drug manufacturer. Only your actual out-of-pocket payments will count toward your annual out-of-pocket maximum. Manufacturer-funded patient assistance will not be considered as true out of pocket for members and may not apply out of pocket maximums.

Many infused medications have manufacturer programs which will financially assist patients in the cost of the medication and infusion provided by the infused medication manufacturer. The SHBP requires that if a financial assistance program is available, you must participate in the program. Only your actual out-of-pocket payments will count toward your annual out-of-pocket maximum. Manufacturer-funded patient assistance for widely distributed specialty drugs will not be considered as true out of pocket for members and may not apply to out-of-pocket maximums.

Preventive Care

Preventive Care Benefits are provided by the SHBP in full compliance with the Patient Protection and Affordable Care Act (PPACA). Required Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services and services received at *In-Network Providers.* Refer to https://www.healthcare.gov/coverage/preventive-care-benefits/.

The SHBP also provides certain preventive care benefits and services that exceed requirements of the PPACA as specified in this Plan Document.

Preventative Care Benefits are provided by the Plan in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items have an "A" or "B" rating from the United States Preventative Services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP), or if the services are recommended by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents (AAP). However, copays, coinsurance and deductibles may apply to other services provided during the same visit and preventative services.

The SHBP also provides certain preventive care benefits and services that exceed requirements of the PPACA as specified in this Plan Document and in compliance with the State of New Jersey Essential Health Benefits Benchmark Plan. For specific benefits covered, see the following links:

- A list of the comprehensive guidelines supported by HRSA is available https://www.hrsa.gov/womens-guidelines/index.html.
- A listing of the items or services with an "A" or "B" rating from USPSTF are available at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
- Immunizations recommended by ACIP are available at http://www.cdc.gov/vaccines/schedules/index.html.
- Services as recommended in the AAP are available at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Pediatric Dental Benefits

The dental benefits described in this dental plan are limited to *Covered Persons* who are under age 19 (from birth through age 18). No benefits are provided for a *Covered Person* who is age 19 or older.

Annual Plan Year Deductible: $0

Your out-of-pocket maximum each *Plan Year*: $1,000

Group 1— Preventive Services and Diagnostic Services		**Schedule of Benefits**
Oral Exams	• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures). • Periodic or routine oral exams; twice in 12 months. • Oral exams for a member under age three; twice in 12 months. • Limited oral exams; twice in 12 months.	100% (no *Deductibles, Copayments,* or *Coinsurance*)
X-rays	• Single tooth x-rays; no more than one per visit. • Bitewing x-rays; twice in 12 months. • Full mouth x-rays; once in 36 months per provider or location. • Panoramic x-rays; once in 36 months per provider or location.	
Routine Dental Care	• Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months or up to four times per year for children with special health care needs. • Fluoride treatments; once per calendar quarter. • Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered). • Space maintainers.	
Group 2—Basic Restorative Services		**Schedule of Benefits**
Fillings	• Amalgam (silver) fillings or Composite resin (white) fillings (for primary, back teeth, payment for a composite filling will not be more than the amount allowed for an amalgam filling).	80% *Coinsurance*.
Bridges	• Bridges.	
Root Canal Treatment	• Root canals. • Vital pulpotomy. • Once per tooth. • Root end surgery.	
Crowns (see also Group 3)	• Prefabricated stainless steel crowns.	
Gum treatment	• Periodontal scaling and root planning or periodontal surgery.	
Prosthetic maintenance	• Repair of partial or complete dentures and bridges; once in 12 months	

	• Reline or rebase partial or complete dentures; once in 24 months • Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth	
Oral surgery	• Simple tooth extractions; once per tooth • Erupted or exposed root removal; once per tooth • Surgical extractions; once per tooth (approval required for complete, boney impactions) • Other necessary oral surgery	
Group 3—Major Restorative Services		**Schedule of Benefits**
Crowns	• Metal only crowns. • Resin crowns. • Porcelain/ceramic crowns. • Porcelain fused to metal/high noble crowns.	50% *Coinsurance*
Tooth replacement	• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months . • Fixed prosthetics (bridges); only if there is no other less expensive adequate dental service; once in 60 months .	
Other necessary services	• Occlusal guards when necessary; once in calendar year • Fabrication of an athletic mouth guard	
Orthodontic Services		**Schedule of Benefits**
Medically necessary orthodontic care that has been preauthorized for a qualified *member*	Braces for a *member* who has a severe and handicapping malocclusion Related orthodontic services for a *member* who qualifies	50% *Coinsurance*

Pediatric Vision Benefits

One visit per plan year for routine vision exam, including refraction and glaucoma testing, covered at 100%. 100% coverage for either prescription lenses and frames or contact lenses, but not both. This coverage is limited to one (1) benefit per *Plan Year*.

This benefit includes contact lenses, glasses, or plastic lenses including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating and low vision items.

State of New Jersey Essential Health Benefits Benchmark Plan

The SHBP complies fully with the State of New Jersey's Essential Health Benefits Benchmark Plan, including compliance with all applicable mandated benefits. Refer to refer to the Section XI, Required Benefits for specific benefit provisions.

General Requirements

The SHBP imposes some conditions on benefits that are common to many health benefit plans. You will get the most out of the benefit program by understanding the following requirements.

- The SHBP provides benefits only for *Covered Expenses/Services* that are *Medically Necessary* for the treatment of a covered *Sickness or Injury*. Not all *Medically Necessary* services are covered. For example, *Experimental or Investigational* treatments are not covered.

- The SHBP provides benefits only for *Covered Expenses/Services* that are equal to or less than the *Reasonable and Customary Charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *Reasonable and Customary Charge* are not recognized by the SHBP for any purpose. *In-Network Providers* charge negotiated rates for their services to the SHBP, which are considered to be the *Reasonable and Customary Charge* for those services. If you use an *Out-of-Network Provider*, you will be responsible for any amounts in excess of the *Reasonable and Customary Charge.*

- The SHBP provides benefits only for *Covered Expenses/Services* rendered by a *Physician* or other *Health Care Provider.*

Princeton Area In-Network Benefits

Physicians and certain other non-hospital *Providers* are available to Covered *Persons* through the CIGNA Network at: www.Cigna.com Refer also to the availability of *In-Network* pharmacy provider for Wellfleet Rx.

The Penn Medicine Princeton Health, Trinity Counseling Services, and counselors, psychiatrists, and other licensed mental *Health Care Providers* have contracted directly with the *Plan Sponsor* to be *In-Network Provider*s and accept the *Preferred Allowance* as full payment for *Covered Expenses/Services*. You identify your eligibility for *Preferred Allowance* charges by showing your Identification Card to the *Provider* when you register with these *In-Network Providers*.

You should be aware that *In-Network Hospitals* may be staffed with *Physicians* and other professional staff who are not in *In-Network Providers*. Unless specified otherwise, the charges of the providers who are out-of-network will not be paid at the *In-Network Provider* level of benefits.

In-Network Benefits Outside of the Princeton Area

The SHBP provides coverage when you receive medical care outside of the *Princeton Area* from an *In-Network Provider.* Generally, the percentage of charges that the SHBP pays is the same as for *Princeton Area In-Network* benefits. The SHBP does not provide all of the benefits specified in the Schedule for SHBP Medical Benefits for *In-Network Providers* in the *Princeton Area* when you receive these same services away from the *Princeton Area*, regardless of your use of an *In-Network Provider.*

Out-of-Network Benefits

You may choose to use a *Physician* or other *Health Care Provider* that is not an *In-Network Provider.* This decision may increase your out-of-pocket costs because of lower coverage levels or charges that exceed the *Reasonable and Customary Charge* allowance. The lack of an available *In-Network Provider* in a specific geographic may not be used as the basis for an appeal of a claim under the SHBP.

Aggregate Plan Year Deductible (Out-of-Network Care Only)

Except as specifically provided for coverage that is subject to *In-Network* services, the *Aggregate Plan Year Deductible* is the amount of *Out-of-Network Covered Expenses/Services* you must pay during each *Plan Year* before the SHBP will consider expenses for reimbursement. The individual deductible applies separately to each *Covered Person*. The family deductible applies collectively to all *Covered Person*s in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered *Family Member* during the remainder of that *Plan Year*.

The *Plan Year* individual and family deductible amounts are shown on the Schedule of Medical Benefits. Expenses from separate *Sicknesses* or *Injuries* may be used to satisfy the *Aggregate Plan Year Deductible.*

Copayments

Dollar *Copayment*s specified on the Schedule of Medical Benefits represent amounts paid by the *Covered Person* before the SHBP pays benefits at the percentage stated in the Schedule of Medical Benefits or in the Schedule of Prescription Drug Benefits.

Coinsurance

After satisfaction of any applicable *Aggregate Plan Year* Deductible or *Copayment*, the SHBP will pay the percentage of charges indicated in the Schedule of Medical Benefits or in the Schedule of Prescription Drug Benefits, subject to the specified maximums.

The SHBP encourages you to use *In-Network Providers* whenever possible. In the *Princeton Area* you will receive a higher benefit level for services from *In-Network Providers*. The *Coinsurance* for In- and *Out-of-Network Providers* is specified in the Schedule of Medical Benefits at the front of this document.

In-Network Providers will not balance-bill you if their charges exceed the *In-Network* fee schedule. You may be balance-billed when charges made by an *Out-of-Network* Provider exceed the *Reasonable and Customary* (U&C) amount for such services.

Out-Of-Pocket Maximums

The out-of-pocket maximum is the maximum amount of charges for *Covered Expenses/Services* a *Covered Person* must pay during a *Plan Year.* The individual out-of-pocket maximum applies separately to each *Covered Person*. When a *Covered Person* reaches the *Plan Year* out-of-pocket maximum, the SHBP will pay 100% of additional *Covered Expenses/Services* incurred by that individual during the remainder of the *Plan Year.* The family out-of-pocket maximum applies collectively to all *Covered Person*s in the same family. When the *Plan Year* family out-of-pocket maximum is reached, the SHBP will pay 100% of *Covered Expenses/Services* for any covered *Family Member* incurred during the remainder of the *Plan Year*.

The *Plan Year* individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits. Any amount applied toward the *In-Network* out-of-pocket maximum will be applied toward the Out-of-Network out-of-pocket maximum and vice versa.

The out-of-pocket maximum does not apply to the following:

- Any expenses not covered or excluded by the SHBP, including expenses which exceed *Reasonable and Customary Charge*s.
- Charges in excess of Benefit Maximums.

Benefit Maximums

Total plan payments for each *Covered Person* are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as *Plan Year* or *Lifetime*.

The benefit maximums applicable to the SHBP are shown on the Benefit Schedules. Unless otherwise specified, maximums apply to combined In- and Out-of-Network benefits. The *Lifetime* maximum applies to combined Medical Benefits and Prescription Drug Benefits.

Medical Case Management

Medical case management is designed to help manage the care of patients who have special or extended care *Sicknesses or injuries*. The primary objective of medical case management is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Medical case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among *Health Care Providers*, patients, and others.

Benefits may be modified by the SHBP *Claims Administrator* to permit a method of treatment not expressly provided for, but not prohibited by law, rules, or public policy, if the SHBP *Claims Administrator* determines that such modification is *Medically Necessary* and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The SHBP *Claims Administrator* also reserves the right to limit payment for services to those amounts which would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Examples of *Sicknesses* or *Injuries* that may be appropriate for medical case management include, but are not limited to:

- Chronic or Terminal *Sicknesses* such as AIDS, cancer, multiple sclerosis, renal failure, chronic obstructive pulmonary disease and cardiac conditions.
- Post-accident long-term rehabilitative therapy.
- Newborns with high-risk complications or multiple birth defects.
- Diagnosis involving long-term IV therapy.
- *Sicknesses* not responding to medical care.
- Child and adolescent *Mental/Nervous Disorders*.

Covered Expenses/Services

When all of the provisions of the SHBP are satisfied, the SHBP will provide benefits as provided in Section VI, Schedule of Medical Benefits, for the services and supplies listed in this Section.

Treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international students and their *Covered* dependents, such SHBP benefits are only provided to the extent they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

Medical Services

- *Physician* home and office visits, as specified in the specified in the Schedule of Medical Benefits.
- *Inpatient* visits by the attending *Physician*.
- Treatment of complications arising from any non-covered *Surgery* or procedure.
- *Second Surgical Opinions*.
- *Third Surgical Opinions*.
- Pregnancy-related care.
- Involuntary termination of pregnancy.
- Treatment of diabetes.
- Dialysis.
- Weight loss programs when prescribed by Health *Care Providers*.
- Surgical and nonsurgical treatment of temporomandibular joint dysfunction.
- Dental services received after an accidental *Injury* to teeth, excluding biting or chewing *Injuries*. This includes replacement of teeth and any related X-rays. Dental services are also covered for medical conditions including the diagnosis and treatment of oral tumors and cysts and the surgical removal of bony impacted teeth. In addition, the SHBP provides benefits for:
  (a) general anesthesia and hospitalization for dental services; and
  (b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by the Contract which requires Hospitalization or general anesthesia.
- *Chiropractic Services.*
- Acupuncture.
- Radiation therapy, including but not limited to high-dose radiotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for treatment of acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy) and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow, but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community.

  Other courses of treatment involving high-dose radiotherapy and autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition are not covered.

- Chemotherapy, including but not limited to high-dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for treatment of acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy) and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow, but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community.

  Other courses of treatment involving high-dose chemotherapy and autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition are not covered.

- Physical therapy as specified in the Schedule of Medical Benefits from a qualified *Health Care Provider*.

- Non-*Custodial Care* services of a *Health Care Provider* which are not billed by a *Home Health Care Agency*.

- Home health care provided by a *Home Health Care Agency*, as specified in the Schedule of Medical Benefits.

- *Hospice* care, as specified in the Schedule of Medical Benefits.

- Speech therapy as specified in the Schedule of Medical Benefits from a qualified *Health Care Provider* to restore speech loss due to a *Sickness, Injury* or surgical procedure.

- Occupational therapy as specified in the Schedule of Medical Benefits from a qualified *Health Care Provider* to restore a physical function.

- *Medically Necessary* treatment of the feet, including treatment of metabolic or peripheral vascular disease.

- Allergy testing and treatment.

- Titer when *Medically Necessary* and not for routine testing.

- Charges for Clinical Trials - Routine costs for items and services furnished in connection with participation in Approved Clinical Trials are covered at the same level as the same services provided outside Approved Clinical Trials, including Hospital visits, imaging and laboratory tests if:

  (a) the referring health care professional is a participating *Health Care Provider* and has concluded that the individual's participation in such trial would be appropriate, or
  (b) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate, and
  (c) these services are Medical Benefits under the SHBP.

Emergency Services

- Ground transportation provided by a professional ambulance service to an emergency care facility equipped to treat a condition that can be classified as a *Medical Emergency*.
- Treatment of an *Accident* in a *Hospital* or other emergency care facility.
- Treatment in a *Hospital* emergency room or other emergency care facility for a condition that can be classified as a Medical Emergency.

Hospital Services

- Semi-private room and board.
- Private room and board, not to exceed the cost of a semi-private room (if available).
- *Intensive Care Unit* and coronary care unit charges.
- Miscellaneous *Hospital* services and supplies required for treatment during a *Hospital* confinement.
- Well-baby nursery, *Physician* and initial exam expenses during the initial *Hospital* confinement of a newborn. Charges for the newborn will be considered as part of the mother's expenses.
- *Outpatient Hospital* services.

Surgical Services

- Surgeon's expenses for the performance of a surgical procedure.
- Assistant surgeon's expenses.
- Two or more surgical procedures performed during the same session through the same or different incisions, natural body orifice or operative field. The amount eligible for consideration is the sum of *Reasonable and Customary Charge*s for each procedure performed.
- *Reconstructive Surgery* when needed to correct damage caused by an accidental *Injury* or a birth defect resulting in the malformation or absence of a body part.
- Anesthetic services, when performed by a licensed anesthesiologist or certified registered *Nurse* anesthetist in connection with a surgical procedure.
- Surgery for morbid obesity (including but not limited to gastroplasty; gastric bypass; and bariatric procedures).
- Circumcision for newborn children.
- *Outpatient Surgery*.

- Podiatric *Surgery*.

- Human organ and tissue transplants, including courses of treatment involving high-dose chemotherapy or radiotherapy and autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy) and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community: Eligible expenses for the donor will also be covered by the SHBP.

  Other courses of treatment involving high-dose chemotherapy or radiotherapy and autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures are not covered as organ and tissue transplants.

Mental/Nervous and Substance Abuse Services

Inpatient treatment of substance abuse and/or a *Mental/Nervous Disorder* are provided for confinement in a *Hospital*, *Mental/Nervous Treatment Facility*, *Residential Treatment Facility*, or Substance *Abuse Treatment Facility*. *Inpatient* benefits include treatment for eating disorders.

Outpatient treatment of substance abuse and/or a *mental/nervous disorder. Outpatient* benefits include but are not limited to: treatment relating to an eating disorder; marital, couples and family counseling (including pre-marital counseling); and treatment of or related to an overdose of drug or medication.

Diagnostic X-Ray and Laboratory Services

- *Diagnostic Charges* for X-rays.

- *Diagnostic Charges* for laboratory services.

- Mammography screening.

- Pre-admission tests (PAT) for a *Hospital* admission.

- Amniocentesis.

- Ultrasound.

- Magnetic Resonance Imaging (MRI).

- Positron Emission Tomography (PET Scan).

- Computerized Axial Tomography (CAT Scan).

- Dual Energy X-ray Absorptiometry, when *Medically Necessary* (DEXA Scan).

- Routine ear and hearing exams.

- Annual routine eye examination by an ophthalmologist or optometrist.

Medical Equipment and Supplies

- *Durable Medical Equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *Physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.

- Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or replacement, if replacement is less expensive than repair of existing equipment.

- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the *Covered Person*.

- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

- Blood and/or plasma and the equipment for its administration.

- Insulin infusion pumps.

- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *Surgery*.

- Wigs and artificial hairpieces, only after chemotherapy or radiation therapy or when it is disease- or *Injury*-related and not due to the normal aging process or premature baldness.

- Occupational therapy supplies.

- Sterile surgical supplies after *Surgery*.

- Jobst garments.

- Hearing aids and related supplies if recommended or presented by a licensed *Health Care Provider* or licensed Audiologist.

Specialized Treatment Facilities

- A *Skilled Nursing Facility* as specifically provided in the Schedule of Medical Benefits.

- A *Mental/Nervous Treatment Facility*.

- A *Substance Abuse Treatment Facility*.

- A *Rehabilitation Facility*.

- An *Ambulatory Surgical Facility*.

- A *Birthing Center*.
- A *Hospice Facility*, including bereavement counseling as specified in the Schedule of Medical Benefits.
- A chemical dependency/substance abuse day treatment facility.
- A *Psychiatric Day Treatment Facility*.

Gender Dysphoria Treatment

Gender reassignment surgery may be indicated for *Covered-Persons* who provide the following documentation:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating *Gender Dysphoria*, is needed for breast surgery. The assessment must document that an individual meets all of the following criteria:
    - Persistent, well-documented *Gender Dysphoria*.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must be at least 18 years of age (age of majority).
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the *Covered Person*, is required for genital surgery. The assessment must document that an individual meets all of the following criteria:
    - Persistent, well-documented *Gender Dysphoria.*
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must be at least 18 years of age (age of majority).
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
    - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
    - Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating *Gender Dysphoria*.

Limitation and Pre-Certification Requirement

This coverage does not apply to *Covered Persons* with ambiguous genitalia or disorders of sexual development. All benefits for treatment of *Gender Dysphoria* are subject to pre-certification by the Claims Administrator for the SHBP. Failure to obtain a pre-certification of treatment for *Gender Dysphoria* will result in exclusion of all expenses incurred.

The specific requirements for *Gender Dysphoria* in adolescents and adults and *Gender Dysphoria* in Children will be shared with the *Covered Person* during the pre-certification process, as well as the specific CPT Codes that are covered by the SHBP.

Additional Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States

- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus.
- Transportation, meals, lodging or similar expenses.
- Cosmetic procedures.
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
- Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.
- Coverage does not apply to members who do not meet the indications listed above.

References for Treatment of Gender Dysphoria

The Plan Sponsor has directed the Claims Administrator to use policies, guidelines, and recommendations of certain insurance organizations and other health care advocacy and research entities, including, but not limited to, the following in making benefit determinations for *Medical Necessi*ty, Covered Drugs (refer to Section X, Prescription Benefits), and administration of other SHBP provisions relating to benefits for *Gender Dysphoria.*

- World Professional Association for Transgender Health (WPATH)
- WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health.
- American College of Obstetrics and Gynecology (ACOG)
- Endocrine Society
- US Food and Drug Administration (FDA)

Medical Benefit Exclusions

The SHBP will not provide medical benefits for any of the items listed below, regardless of *Medical Necessity* or recommendations of a *Physician* or *Health Care Provider*.

- Any treatment of a condition that is not a covered *Sickness* or *Injury* or any service or supply that is not specifically listed in Section IX, Medical Benefits or Section VIII, Required Benefits.
- Expenses exceeding the *Reasonable and Customary Charge* for the geographic area in which services are rendered.
- Treatment provided by a *Close Family Member* or treatment that is not prescribed or recommended by a *Physician or Health Care Provider*.
- Services, supplies or treatment not *Medically Necessary*.
- *Cosmetic Surgery*, treatment, procedures, services or supplies, except *Surgery* required to correct an *Injury* for which benefits are otherwise payable, care for newborn or adopted children, and *Cosmetic Surgery* following treatment for breast cancer as provided in Required Benefits.
- Services or supplies for which there is no legal obligation to pay for expenses, or charges which would not be made except for the availability of benefits under the SHBP. This includes any expense incurred by an international student or dependent that would also be covered by under another insurance plan, program, or system of socialized medicine in the absence of SHBP coverage.
- *Experimental or Investigational* equipment, services or supplies.
- Services furnished by or for the United States government or any other government, unless payment is legally required.
- Any condition, disability or expense sustained as a result of being engaged in an illegal occupation; commission or attempted commission of an assault or other illegal act (regardless of whether charges are filed by a law enforcement agency).
- Intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot or a war; or act of war which is declared or undeclared.
- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the *Covered Person* to a benefit under a Worker's Compensation Act or similar legislation.
- Educational, vocational, or training services and supplies.
- Expenses for preparing medical reports, itemized bills, or claim forms. Mailing and/or shipping and handling expenses.
- Expenses for broken appointments, telephone call consultations, or electronic mail, Web, or Internet-based consultations. To the extent permitted by federal or state laws and regulations, including any

emergency orders permitting the use of telemedicine issued by the State of New Jersey, this exclusion does not apply telemedicine or Internet-based health care services.

- Services or supplies furnished, paid for or for which benefits are provided or required by reason of past or present service of any *Covered Person* in the armed forces of a government.
- Travel expenses of a *Physician.*
- Travel expenses of a *Covered Person* other than local ambulance services to nearest medical facility equipped to treat the illness or *Injury*, expect as specified in the Schedule of Medical Benefits.
- *Custodial Care*.
- Expenses used to satisfy plan *Deductibles*, *Copayments*, or *Coinsurance* amounts.
- Expenses incurred for services rendered prior to the effective date of coverage under the SHBP or after coverage terminates, even though illness or *Injury* started while coverage was in force.
- Sales tax.
- Personal comfort or service items while confined in a *Hospital,* such as, but not limited to, radio, television, telephone and guest meals.
- Any *Inpatient* or residential treatment facility that is not included in the Section XVII, Definitions.
- Penile prosthetic implants.
- Reproductive sterilization.
- Services for or related to *Reconstructive Surgery* or *Cosmetic Surgery*, except as specifically provided in the Schedule of Medical Benefits.
- Orthognathic *Surgery* or mandibular retrognathia *Surgery*.
- Massage therapy or rolfing.
- Sex counseling.
- Eye examinations for diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy or supplies, except as specifically provided in Section VIII, Required Benefits. Any refractive eye *Surgery* or procedure designed to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including, but not limited to, LASIK, radial keratotomy and keratomileusis *Surgery*.
- Adoption expenses.
- Surrogate expenses.
- Biofeedback.

- Hypnosis.
- Genetic counseling or genetic testing, except as specifically provided in Section VIII, Required Benefits for BRCA counseling about genetic testing for women at higher risk.
- Expenses incurred for non-surgical treatment of the feet, including treatment of corns, calluses and toenails, or other routine foot care, except as specified in Covered Medical Expenses.
- Expenses for *Outpatient* prescription drugs or medicines (Refer to Section X, Prescription Drug Benefits for separate prescription drug coverage under the SHBP). Expenses for supplies that do not require a *Physician's* prescription (i.e., over-the-counter medications).
- Services or supplies that are primarily and customarily used for a non-medical purpose, or used for environmental control or enhancement (whether or not they are *Medically Necessary* or prescribed by a *Physician* or other *Health Care Provider*), including but not limited to: equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *Sickness or Injury*.
- Expenses for services and supplies in excess of Benefit Maximums.
- Services for or related to smoking cessation program fees and/or related program supplies, except as specifically provided in the Section VIII, Required Benefits.
- Services for treatment of mental retardation, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), or any other learning disability.
- Voluntary termination of pregnancy.
- Circumcision, except as specifically provided for newborn children.
- Claims originally submitted more than one year after the date on which the service or supply was incurred.
- Expenses incurred for failure to obtain a pre-certification of benefits as required herein. Benefits may be totally excluded or reduced as specified in the Section VI, Schedule of Medical Benefits.

General Requirements

Prescription Drug benefits are payable in connection with covered prescriptions and refills dispensed by licensed pharmacists. Although a *Physician's* prescription is required, such prescription does not guarantee that a particular drug will be covered by the SHBP.

The SHBP has selected Wellfleet Rx as the prescription benefit program manager. When you fill a covered prescription at a Wellfleet Rx participating pharmacy and show your SHBP Identification Card with the Wellfleet Rx logo, the pharmacy will submit the claim on your behalf and accept the *Maximum Allowable Cost* as full payment. You pay only your *Copayment* specified in the Prescription Drug Schedule of Benefits.

When you fill a covered prescription at a pharmacy outside the Wellfleet Rx Network, you must pay for the full cost of the purchase and then submit a claim for benefits to Wellfleet Rx to be reimbursed. A pharmacy that does not participate with Wellfleet Rx may charge you either more than the *Maximum Allowable Cost* or an amount in excess of the SHBP's *Reasonable and Customary Charge* allowance. Charges in excess of the *Maximum Allowable Cost* or the SHBP's *Reasonable and Customary Charge* allowance are not covered by the SHBP.

Covered Drugs

Expenses for the following items are eligible for benefits unless listed as an exclusion below:

- Federal *Legend* Drugs and State Restricted Drugs.
- Compounded medications of which at least one ingredient is a *Legend* drug.
- Insulin (including insulin needles and diabetic supplies).
- Oral contraceptives that require a *Physician's* prescription.
- *Legend* smoking deterrents.
- *Legend* vitamin B12 (all dosage forms).
- Prenatal vitamins.
- Fertility. Only artificial insemination and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs are covered
- Emergency allergic kits.
- Imitrex (all dosage forms).
- Glucagon emergency kits.
- Synagis and Respigam.
- Allergy serums (all dosage forms).
- Injectable prescription medications.

Dispensing Limits

The dispensing limits are specified in the Schedule of Prescription Drug Coverage.

Prescription Drug Benefit Exclusions

Expenses for the following are not covered by the SHBP unless specifically listed as a benefit under Covered Drugs:

- Charges for drugs, medicines, services or supplies prescribed by a *Physician* or any other *Health Care Provider* only on the basis of an online, internet or telephonic consultation not preceded by an in-person medical examination with that *Physician* or other *Health Care Provider*.
- Drugs not classified as Federal *Legend* Drugs (i.e., over-the-counter drugs and products, except for Plan B® One Dose).
- Impotency drugs.
- *Legend* vitamins and nutritional supplements.
- Dental fluoride products.
- Cosmetic drugs and drugs used to promote or stimulate hair growth.
- Glucowatch products and glucose monitors (refer to the Section XI, REQUIRED BENEFITS, for benefits relating to diabetes).
- Biologicals, immunizations agents or vaccines, blood or blood plasma.
- Drugs labeled "Caution-Limited by Federal law to Investigational Use," or experimental drugs, even though a charge is made to the individual.
- Any prescription refilled in excess of the number of refills specified by the ordering *Physician*, or any refill dispensed one year after the original order.
- Medication dispensed in excess of the Dispensing Limits.
- Charges for the administration or injection of any drug.
- Substance abuse treatments.
- Ostomy supplies.
- Therapeutic devices and supplies.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *Hospital*, rest home, sanitarium, extended care facility, *Skilled Nursing Facility*, convalescent *Hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

- Services or products that are determined by the SHBP as not *Medically Necessary.*

- Mail order medications for 90-day supplies after July 1 of any *Plan Year*.

- Claims originally submitted more than one year after the date on which the service or supply was incurred.

Mail Order Prescription Drugs

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Wellfleet Rx Mail Service Prescription Drug Program. Using the Mail Service Prescription Drug Program, a 90-day supply of a medication can be filled with a *Copayment* that is 2 times the *Copayment* of a 30-day supply. When you use the Mail Service Prescription Drug Program you will need to complete a Wellfleet Rx By Mail Order Form and mail it directly to Wellfleet Rx along with your doctor's signed prescription form. After submitting your initial prescription, additional prescriptions can be filled by going online to http://www.wellfleetrx.com.

Many of the benefits and services covered in this Section are provided for the SHBP's full compliance with the State of New Jersey's Essential Health Benefits Benchmark Plan.

Except for services or supplies covered at 100 percent under Section VIII, Required Care Benefits, all Special Provision benefits will be subject to the Deductible and *Coinsurance* provisions of the SHBP, except as specifically provided. The *Medical Necessity* requirement also applies to all Required Benefits, unless otherwise specified.

Integration with Required Benefits
If State of New Jersey Required Benefits are in conflict with Section VIII, ACA Required Benefits, the SHBP will provide the highest level of benefits possible between the two mandates for coverage.

Benefits for Audiology and Speech Language Pathology
Benefits will be paid the same as any other *Sickness* for Audiology and Speech Language Pathology when such services are determined by a *Physician* to be *Medically Necessary* and are performed or rendered to the *Covered Person* by a licensed audiologist or speech language pathologist.

Benefits for Cervical Cancer Screening
Benefits will be paid the same as any other *Sickness* for an annual pap smear or a pap smear done more frequently than annually if recommended by a *Provider*. The benefit shall include an initial pap smear and any confirmatory test when *Medically Necessary* and are ordered by the *Covered Person's Provider* and includes all laboratory cost associated with the initial pap smear and any such confirmatory test.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Colorectal Cancer Screening
Benefits will be paid the same as any other *Sickness* for colorectal cancer screening at regular intervals for *Covered Person* age 50 and over and for *Covered Persons* of any age who are considered to be at high risk for colorectal cancer. "High risk for colorectal cancer" means a person has: (1) a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps; (2) Chronic inflammatory bowel disease; or (3) a background, ethnicity, or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer.

The methods of screening for which benefits are provided shall include: (1) a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or (2) the most reliable, medically recognized screening test available. The method and frequency of screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined *Medically Necessary* by the *Covered Person's Health Care Provider*, in consultation with the *Covered Person*. Benefits are subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Diabetes
Benefits will be paid the same as any other *Sickness* for the following equipment and supplies for the treatment of diabetes if recommended or prescribed by a *Health Care Provider* or clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Benefits shall also include self-management education to ensure that an Insured Person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.

Benefits provided for self-management education and education relating to diet shall be limited to visits *Medically Necessary* upon the diagnosis of diabetes; upon diagnosis by a *Health Care Provider* or clinical nurse specialist of a significant change in the *Covered Person's* symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a *Health Care Provider* or clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions specified in this Plan Document.

Benefits for Domestic Violence Injuries

Benefits for treatment of Domestic Violence injuries are provided by the SHBP, subject to the terms and conditions of this Plan Document.

Benefits for Health Wellness Examinations

Benefits will be provided at 100 percent, not subject to copayments, deductible, or coinsurance, for wellness health exams and counseling:

- For all *Covered Persons* 20 years of age or older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level; or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level;
- For all *Covered Persons* 35 years of age or older: a glaucoma eye test every five years.
- For all *Covered Persons* 40 years of age or older: an annual stool examination for presence of blood.
- For all *Covered Persons* 45 years of age or older: a left-sided colon examination of 35 to 60 centimeters every five years.
- For all *Covered Women* 20 years of age or older, a pap smear every 2 years.
- For all *Covered Women* 40 years of age or older, a mammogram examination pursuant to the Mammography Coverage benefit.
- For all Covered Persons a digital tomosynthesis
- For all Covered Persons recommended immunizations; and
- For all Covered Persons 20 years of age or older, annual consultation with a *Physician* to discuss lifestyle behaviors that promote health and well-being including, but not limited to smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination, and seat belt usage in motor vehicles.

Benefits for Hearing Aids

Benefits will be paid the same as any other *Sickness* for *Medically Necessary Covered Expenses* incurred for the purchase of a hearing aid for a *Covered Person*. Benefits include one hearing aid for each ear when prescribed or recommended by a licensed *Provider* or audiologist. Benefits are limited to one hearing aid for each hearing-impaired ear during a 24-month period. Benefits shall be subject to all *Deductible, Copayment, Coinsurance, limitations,* or any other provisions of the SHBP.

Benefits for Home Health Care

Benefits will be paid the same as any other *Sickness* for Home Health Care as hereinafter defined. "Home Health Care" means those nursing and other home health care services rendered to an Insured who is the patient in his place of residence, under all the following conditions:

- On a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis.
- If continuing Hospitalization would otherwise have been required if home health care were not provided.
- Pursuant to a Provider's written order and under a plan of care established by the responsible Provider working with a Home Health Care Provider. The Provider must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Provider may not be related to the Home Health Care Provider by ownership or contract. All care plans shall be established within 14 days following commencement of home health care.
- Home health care services will include benefits for hemophilia, including expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of State approved hemophilia treatment center. These benefits shall be provided to the same extent as any other *Sickness* under the Plan Document. "Blood product" includes, but is not limited to Factor VIII, Factor IX and cryoprecipitate. "Blood infusion equipment" includes, but is not limited to, syringes and needles.

"Home Health Care Services" means any of the following services which are *Medically Necessary* to achieve the plan of care referred to in condition (3) above and are provided for the care of *the Covered Person*: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this Plan Document if the *Covered Person* were in a *Hospital*; and any diagnostic or therapeutic service, including surgical services performed in a *Hospital* outpatient department, a Provider's office or any other licensed health care facility, to the extent such service would be covered by the SHBP if performed as an inpatient Hospital service, provided that service is performed as part of the plan of care.

Limitations -- Home Health Care Benefits are subject to the following limitations:

- Services must follow a Hospital Confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
- Any visit by a member of a home health care team on any day will be considered one (1) home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.
- The amount payable for a home health care visit shall not exceed for each of the first three days on which services are provided the daily room and board benefit provided by the SHBP during the prior confinement; for each subsequent day of such services, the amount payable shall not exceed one-half of the daily room and board benefit provided by this Plan Document during the prior confinement.
- The services and supplies must be furnished and charged for by a Home Health Care agency or provider.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Anesthesia and Hospitalization for Dental Services

Benefits will be paid the same as any other *Sickness* for a *Covered Person* who is severely disabled or a child age five (5) or under Refer to Section IX, Medical Benefits, for benefits pertaining to dental care services. incurred for *Covered Expenses* for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the SHBP which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided. Benefits shall be subject to all *Deductible, Copayment, Coinsurance, limitations*, or any other provisions of the SHBP.

Refer also to Section IX, Medical Benefits, for benefits pertaining to dental care services and Section VIII, ACA Required Benefits.

Benefits for Hospital Confinements for Pregnancy

A *Hospital* confinement for the purpose of delivery of a *Newborn Child* will be allowed for no less than 48 hours following a vaginal delivery and 96 hours following a cesarean section.

Benefits for Non-Standard Infant Formulas

Benefits will be paid on the same basis as other Prescription Drugs for the purchase of specialized non-standard infant formulas, when the Covered infant's *Physician* has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be *Medically Necessary,* and when the Covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Benefits for Infertility Treatment

Benefits will be paid the same as any other sickness for Medically Necessary expenses incurred in the diagnosis and treatment of Infertility for a *Covered Person.* Benefits include, but are not limited to the following services related to Infertility" diagnosis and diagnostic tests; medications; surgery; in vitro fertilization (IVF); embryo transfer; artificial insemination; gamete intra fallopian transfer (GIFT); zygote intra fallopian transfer (ZIFT); intracytoplasmic sperm injection (ICSI); and four completed egg retrievals per lifetime of the *Covered Person.*

In vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer shall be limited to a Covered Person who: (a) has used all reasonable, less expensive, and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy; (b) has not reached the limit of four (4) complete egg retrievals' and (c) is 45 years of age or younger.

As used in this benefit:

"Infertility' means a disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the Covered Person has met on of the following conditions:

1. A male is unable to impregnate a female.
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse.
3. A female with a male partner and 35 years of age or over is unable to conceive after 6 months of unprotected sexual intercourse.
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
5. A female without a male partner and over 35 years of age who is unable to conceive after 6 failed attempts of intrauterine insemination under medical supervision;
6. Partners are unable to conceive as a result of involuntary medical sterility;
7. A Covered Person is unable to carry a pregnancy to live birth; or
8. A previous determination of infertility pursuant to this section.

Benefits for Fertility Preservation Services
Benefits will be paid the same as any other Sickness for standard Fertility Preservation services when Medically Necessary treatment may directly or indirectly cause Iatrogenic Infertility.

"Iatrogenic Infertility" means an impairment of fertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Standard fertility preservation services mean procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.

We will not discriminate based on the Covered Persons's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status, or gender identity, when determining coverage under this benefit.

Benefits for Treatment of Inherited Metabolic Diseases
Benefits will be paid the same as any other Sickness for Covered Medical Expenses for therapeutic treatment of Inherited Metabolic Diseases, including the purchase of Medical Foods and Low Protein Modified Food Products, when diagnosed and determined to be *Medically Necessary* by the *Physician*.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a *Physician* for the dietary treatment of an inherited metabolic disease but does not include a natural food that is naturally low in protein.

*"*Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be either consumed under the direction of a *Physician* or administered internally under direction of a *Physician*.

Benefits shall be subject to all Deductibles, Copayments, Coinsurance, Limitations, and any other provision of this Plan Document.

Benefits for Infusion Therapy
Benefits for Infusion Therapy are provided by the SHBP, subject to the terms and conditions of this Plan Document.

Benefits for Lead Poisoning Screening for Children, Newborn Hearing Loss, and Childhood Immunizations
Benefits will be paid the same as any other *Sickness*, except that no Deductible will be applied, for the following services:

1. Screening by blood lead measurement for lead poisoning for eligible Dependent Children, including confirmatory blood testing as specified by the New Jersey Department of Health and Senior Services and including medical evaluation and any necessary medical follow-up or treatment for lead poisoned eligible Dependent Children.
2. Screening for Newborn Hearing Loss by appropriate electrophysiologic screening measures and periodic monitoring of eligible Dependent Infants for delayed onset hearing loss.

3. All childhood Immunizations as recommended by the Advisory on Immunization Practices of the United States Public Health Service and the New Jersey Department of Health.

Benefits shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Maternity Testing
Benefits will be paid the same as any other *Sickness* for routine maternity tests and screening exams, subject to the terms and conditions of this Plan Document.

Benefits for Nutrition Counseling
Nutrition counseling is provided by the SHBP for management of disease with specific criteria that can be verified (including diabetes), subject to the terms and conditions of this Plan Document.

Benefits for Inpatient Coverage for Mastectomies
Benefits will be paid the same as any other Sickness for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy.

Benefits for Reconstructive Breast Surgery
Benefits will be paid the same as any other *Sickness* for reconstructive breast *Surgery* following a mastectomy on one breast or both breasts. Coverage is also provided for physical complications of mastectomy as any other *Sickness*, including lymphedemas. This benefit also includes the cost of prosthesis. The cost of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer shall be included as part of the outpatient x-ray or radiation therapy coverage.

Benefits for Mammography
Benefits will be paid the same as any other *Sickness* for a mammogram according to the following guidelines:

1. One baseline mammogram for women who are less then 40 years of age;
2. One mammogram every year for women age 40 and over;
3. Any women under the age of 40 and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at age intervals as deemed Medically Necessary by the Physician.

Benefits will also be provided for an ultrasound evaluation, an MRI scan, a three-dimensional mammography, or other additional testing of an entire breast or breasts, after a baseline mammogram exam:

1. If the mammogram:
    a. Demonstrates extremely dense breast tissue.
    b. Is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue.
2. If the *Covered Person* has additional risk factors for breast cancer, including but not limited to:
    a. Family History of breast cancer.
    b. Prior personal history of breast cancer.
    c. Positive genetic testing.
    d. Extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
    e. Other indication as determined by the *Covered Person's* Physician.

Benefits for Digital Tomosynthesis of the Breast
Benefits will be provided for digital tomosynthesis to detect or screen for breast cancer. Benefits for digital tomosynthesis conducted to detect or screen for breast cancer in women 40 year of age and over are (1) not be subject to any Deductible, Copayment, or Coinsurance and (2) are subject to the limitations or any other provisions of this Plan Document. Benefits for digital tomosynthesis conducted for diagnostic purposes in women on any age shall be paid as any other Sickness and subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Contraceptive Services and Devices
Benefits will be provided with no Deductible, Copayment, or Coinsurance for the following services, drugs, devices, products, and procedures with received from a Preferred Provider.

1. Any contraceptive drug, device, or product approved by the United States Food and Drug Administration (FDA) are subject to all of the following conditions:
    a. If there is a therapeutic equivalent of a contraceptive drug, device, or product by the FDA, coverage will be provided for either the requested contraceptive drug, device, or product or for one or more therapeutic equivalents of the requested contraceptive drug, device, or product.
    b. Coverage is provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the FDA.
    c. Coverage is provided without any infringement of a *Covered Person's* choice of contraception and Medically Necessity will be determined by the *Covered Persons* Physician for covered contraceptive drugs, devices, or other products approved by the FDA.
2. Voluntary male and female sterilization.
3. Patient education and counseling on contraception.
4. Services related to the administration of monitoring of drugs, devices, products, and services required under this benefit, including but not limited to:
    a. Management of side effects.
    b. Continued Counseling for adherence to a prescribed regimen.
    c. Device insertion and removal.
    d. Provision of alternative contraceptive drugs, devices, or products deemed medically appropriate in the judgement of the Covered Person's Physician.
    e. Diagnosis and treatment of services provided pursuant to, or as a follow-up to, a service required under this benefit.
5. Benefits will also include dispensing of contraceptive prescriptions for up to 12-month periods at one time.

All other Contraceptive Services and Devices covered under the Policy will be paid the same as any other *Sickness* and shall be subject to all deductibles, copayments, coinsurance, limitations, or any other provisions of this Plan.

Benefits for Sickle Cell Anemia
Benefits will be paid the same as any other *Sickness* for diagnosis and treatment of Sickle Cell Anemia, subject to the terms and conditions of this Plan Document.

Benefits for Prostate Cancer Testing (PSA)
Benefits will be paid the same as any other *Sickness* for an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen (PSA) test for men age 50 and over who are asymptomatic and for age 40 and over with a family history of prostate

cancer or other prostate cancer risk factors. Benefits are subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Treatment of Wilm's Tumor
Benefits will be paid the same as any other *Sickness* for the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed *Experimental or Investigational*.

Benefits Orthotic and Prosthetic Appliances
Benefits will be paid based on the Medicare allowance amount for Orthotic and Prosthetic appliances when such appliances are determined by a *Provider* to be *Medically Necessary* and are obtained by the *Covered Person* from a licensed orthotist or prosthetist or a certified pedorthist.

"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.

"Prosthetic appliance" means any artificial device that is not surgically implanted and 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 or other devices which should not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Donated Human Breast Milk
Benefits will be paid the same as any other *Sickness* for expenses incurred in the provision of pasteurized donated human breast milk, which may include human milk fortifiers, if indicated by the prescribing *Provider*. Benefits are subject to the following conditions:

1. The *Covered Person* is an infant under the age of six (6) months.
2. The milk is obtained from a human milk bank that meets the quality guidelines established by the Department of Health.
3. A *Provider* has issued an order for an infant who: (a) is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; o (b) meets any of the following:
    - has a body weight below healthy levels determined by the Provide;
    - has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;
    - has a congenital or acquired condition that may benefit from the use of donor breast milk as determined by the Department of Health;

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Breastfeeding Support

Benefits will be provided for comprehensive lactation support, counseling, and consultation, and the costs for renting or purchasing breastfeeding equipment, in conjunction with each birth, for the duration of breastfeeding for the *Covered Person*. Benefits are not subject to the Deductible, Copayment, Coinsurance, limitations or any other provisions of this Plan Document.

Benefits for Oral Chemotherapy Drugs

Benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to a *Covered Person* as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Prescription Eye Drops

Benefits will be paid the same as any other medical or prescription drug condition for expenses incurred for refills of prescription eye drops in accordance with the Guidance for Early Refill Edits of Topical Ophthalmic Products provided that (1) the prescribing *Provider* indicates on the original prescription that additional quantities of the prescription eye drops are needed and (2) The requested refill does not exceed the number of additional quantities indicated on the original prescription.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document.

Benefits for Medication Synchronization

Benefits for Prescription Drugs shall include the following:

1. A prorated daily Copayment amount for Prescription Drugs that are dispensed by a Network Pharmacy for less than a 30-day supply if the *Provider* or pharmacist that the fill or refill is in the best interest of the *Covered Person* or is for the purpose of synchronizing the *Covered Person's* chronic medications.
2. Coverage for a Prescription Drug for the treatment of a chronic *Sickness* which is dispensed in accordance with a plan between the *Covered Person*, the *Provider*, and the pharmacist to synchronize the refilling of multiple Prescription Drugs for the *Covered Person*.
3. Dispensing fees, if any, based exclusively on the total number of prescriptions dispensed.

This section does not apply to prescriptions for opioid analgesics. Opioid analgesics are drugs in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in mediate release or extended-release form, and whether or not combined with other drug substances to form a single drug product or dosage form.

Medication synchronization shall be provided on at least one occasion per *Plan Year,* per *Covered Person*.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of this Plan Document

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General Provisions

When you and/or your dependents are covered under more than one medical plan, one plan is considered primary and the other secondary. The primary plan always pays first and usually pays full regular benefits while the secondary plan may pay a portion of the claim not paid by the other plan. This is known as coordination of benefits.

Except as specifically provided, the SHBP will be primary in coordinating benefits with other insurance programs. As primary coverage, the SBHP will reimburse eligible medical expenses before other insurance makes payments for a claim. This Coordination of Benefits provision is subject to some limitations: (1) the SHBP will pay no more than it would have paid if it had been primary, and (2) the amount that the SHBP pays, combined with the amount paid by the other plan, will not exceed the total amount of eligible medical expenses incurred.

For purposes of coordination, eligible medical expenses mean any *Medically Necessary* charges considered in part or full by the SHBP.

The Student Health Benefits Plan will coordinate coverage for dependents:

- When the SHBP covers a dependent child of non-divorced or non-separated parents and the parent with coverage under the SHBP has the earlier birth date (month and day) in the year. If both parents have the same birth date, the SHBP covering the child for the longest period of time will be primary.

- When the SHBP covers the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses

- In the absence of a court order specifying otherwise, the SHBP covers the dependent child of the natural parent having legal custody of the child.

- In the absence of a court order specifying otherwise, the SHBP covers the stepchild residing with a stepparent who is the spouse of the natural parent having legal custody of the child.

Government Programs

The regulations governing *Medicare, Medicaid* and CHAMPUS/Tricare take precedence over the determination of the SHBP. For example, in determining the benefits payable under the SHBP, the SHBP will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a *Medicaid* plan.

Other Group Plans

Any group health plan that does not contain a coordination of benefits provision will be considered primary.

Right To Make Payments To Other Organizations

Whenever payments, which should have been made by the SHBP, have been made by any other plans(s), the SHBP has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under the SHBP and, to the extent of such payments, the SHBP will be fully released from any liability regarding the *Covered Person* for whom payment was made.

Payment Condition

(1) The SHBP may elect, but is not required, to conditionally advance payment of medical benefits in those situations where an *Injury, Illness*, disease, or disability is caused, in whole or in part, by, or results from, the acts or omissions of a third party, or the acts or omissions of a *Covered Person* ("SHBP Beneficiary") where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, or other insurance policies or funds ("Coverage") is available.

(2) A SHBP Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the SHBP's payment of medical benefits, to maintain one hundred percent (100%) of the SHBP's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the SHBP or its assignee. By accepting benefits under the SHBP, the SHBP Beneficiary recognizes the property right or equitable interest of the SHBP in any cause of action the SHBP Beneficiary may have and the proceeds thereof.

(3) In the event a SHBP Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the SHBP Beneficiary agrees to reimburse the SHBP for all benefits paid or that will be paid. The SHBP Beneficiary acknowledges that the SHBP has the first priority right of recovery and a first lien to the extent of benefits provided by the SHBP. If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (fees and costs) employed with the SHBP's attempt to recover such money from the SHBP Beneficiary.

Subrogation

(1) As a condition to participating in and receiving benefits under this SHBP, the SHBP Beneficiary agrees to subrogate the SHBP to any and all claims, causes of action or rights that may arise against any person, corporation, and/or entity, and to any Coverage for which the SHBP Beneficiary claims an entitlement, regardless of how classified or characterized. The SHBP Beneficiary agrees to reimburse the SHBP for any such benefits paid when judgment or settlement is made.

(2) If the SHBP Beneficiary decides to pursue a third party or any Coverage available as a result of the said *Injury* or condition, the SHBP Beneficiary agrees to include the SHBP's subrogation claim in that action. If there is a failure to do so, the SHBP will be legally presumed to be included in such action.

(3) The SHBP may, in its own name or in the name of the SHBP Beneficiary or their personal representative, commence a proceeding or pursue a claim against such other third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the SHBP.

(4) The SHBP Beneficiary then authorizes the SHBP to pursue, sue, compromise, or settle any such claims in their name and agrees to cooperate fully with the SHBP in the prosecution of any such claims.* This includes the failure of the SHBP Beneficiary to file a claim or pursue damages against:

(a) the responsible party, their insurer, or any other source on behalf of that party;

(b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;

(c) any policy of insurance from any insurance company or guarantor of a third party;

(d) any worker's compensation or other liability insurance company; or

(e) any other source, including but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

* The SHBP Beneficiary, his or her guardian, or the estate of a SHBP Beneficiary, assigns all rights to the SHBP or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

Right of Reimbursement

(1) The SHBP shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, the make whole doctrine, the Rimes Doctrine, or any other similar legal theory, and without regard to whether the SHBP Beneficiary is fully compensated by his/her net recovery from all sources. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the SHBP Beneficiary's recovery is less than the benefits paid, then the SHBP is entitled to be paid all of the recovery achieved.

(2) The SHBP will not be responsible for any expenses, attorney fees, costs, or other monies incurred by the attorney for the SHBP Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigious nature may be deducted from the SHBP's recovery without the prior expressed written consent of the SHBP.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords protection to patients from unwarranted disclosure of private medical information by specifying those situations in which, and those persons to whom, personal information may be disclosed.

Permitted Disclosures

There are three circumstances under which the SHBP may disclose an individual's protected health information to the *Plan Sponsor*.

(1) The SHBP may inform the *Plan Sponsor* whether an individual is enrolled in the SHBP.

(2) The SHBP may disclose summary health information to the *Plan Sponsor*. The *Plan Sponsor* must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SHBP. Summary health information is information that summarizes claims history, claims expenses, and/or types of claims without identifying the individual.

(3) The SHBP may disclose an individual's protected health information to the *Plan Sponsor* for SHBP administrative purposes. This is because the *Plan Sponsor* performs many of the administrative functions necessary for the management and operation of the SHBP. The *Plan Sponsor* has certified to the SHBP that the SHBP's terms have been amended to incorporate the terms of this summary. The *Plan Sponsor* has agreed to abide by the terms of this summary. The SHBP's privacy notice also permits the SHBP to disclose an individual's protected health information to the *Plan Sponsor* as described in this summary.

Restrictions on Plan Administrator and Disclosure

The restrictions that apply to the *Plan Sponsor*'s use and disclosure of an individual's protected health information are as follows:

(1) The *Plan Sponsor* will only use or disclose an individual's protected health information for SHBP administrative purposes, as required by law, or as permitted under HIPAA regulations. (Refer to SHBP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.)

(2) If the *Plan Sponsor* discloses any of an individual's protected health information to any of its agents or subcontractors, the *Plan Sponsor* will require the agent or subcontractor to keep an individual's protected health information confidential as required by the HIPAA regulations.

(3) The *Plan Sponsor* will not use or disclose an individual's protected health information for the *Plan Sponsor* admissions-related or employment-related actions or decisions or in connection with any other benefit or benefit plan of the *Plan Sponsor* unless permitted under HIPAA.

(4) The *Plan Sponsor* will promptly report to the SHBP any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

(5) The *Plan Sponsor* will allow an individual or the SHBP to inspect and copy any protected health information about that individual who is in the *Plan Sponsor*'s custody and control. The HIPAA Regulations set forth the rules that an individual and the SHBP must follow in this regard. There are some exceptions to this provision allowed under federal regulations.

(6) The *Plan Sponsor* will amend, or allow the SHBP to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.

(7) With respect to some types of disclosures, the *Plan Sponsor* will keep a disclosure log for a period of not less than six (6) years. An individual has a right to see the disclosure log. The *Plan Sponsor* does not have to maintain the log if disclosures are for certain SHBP-related purposes, such as payment of benefits or health care operations.

(8) The *Plan Sponsor* will make its internal practices, books, and records relating to its use and disclosure of an individual's protected health information available to the SHBP and to the U.S. Department of Health and Human Services.

(9) The *Plan Sponsor* will, if feasible, return or destroy all of an individual's protected health information in the *Plan Sponsor*'s custody or control that the *Plan Sponsor* has received from the SHBP or from any business partner, agent, or subcontractor when the *Plan Sponsor* no longer needs an individual's protected health information to administer the SHBP. If it is not feasible for the *Plan Sponsor* to return or destroy an individual's protected health information, the *Plan Sponsor* will limit the use or disclosure of such protected health information.

Authorized Recipients of Protected Health Information

The following classes of individuals or other workforce members under the control of the *Plan Sponsor* may be given access to an individual's protected health information on a need-to-know basis, solely for the purposes set forth above:

(a) the Plan Administrator.
(b) The SHBP Management Committee.
(c) Professional staff and/or clinicians or counselors of the *Plan Sponsor*'s Counseling Center; and
(d) Consultants or other third parties retained by the *Plan Sponsor* to perform duties necessary for the function of the SHBP.

This list includes every class of individuals or other workforce members under the control of the *Plan Sponsor* who may receive an individual's protected health information. If any of these individuals or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the responsible individual(s) or workforce member(s) will be subject to disciplinary action and sanctions. If the *Plan Sponsor* becomes aware of any such violations, the *Plan Sponsor* will promptly report the violation to the SHBP and will cooperate with the SHBP to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual.

Security Provisions

The *Plan Sponsor* will receive or generate electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the *Plan Sponsor* certifies to the SHBP that it agrees to:

(1) take appropriate and reasonable safeguards (administrative, physical, and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains, or transmits.

(2) require that any agent or subcontractor of the *Plan Sponsor* agrees to the same requirements that apply to the *Plan Sponsor* under this provision.

(3) report to the SHBP any security incident of which the *Plan Sponsor* becomes aware; and

(4) apply reasonable and appropriate security measures to maintain adequate separation between the SHBP and *Plan Sponsor*.

Allocation of Authority

The Plan Administrator will control and manage the operation and administration of the SHBP. The Plan Administrator shall have the sole and exclusive right and discretion:

(1) to interpret the SHBP, the Plan Document, and any other writings affecting the establishment or operation of the SHBP, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the SHBP, including the right to remedy possible ambiguities, inconsistencies, or omissions; and

(2) to make factual findings and decide conclusively all questions regarding any claim for benefits made under the SHBP.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the SHBP will be conclusive and binding on all persons.

Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the SHBP as a condition to receiving any benefits under the SHBP;

(2) to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the SHBP;

(3) to decide on questions concerning the SHBP, or the eligibility of any person to participate in the SHBP, in accordance with the provisions of the SHBP;

(4) to determine the amount of benefits that will be payable to any person in accordance with the provisions of the SHBP;

(5) to inform *Covered Person(s)*, as appropriate, of the amount of such benefits payable in accordance with the provisions of the SHBP;

(6) to provide a full and fair review to any *Covered Person* whose claim for benefits under the SHBP has been denied in whole or in part;

(7) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the SHBP;

(8) to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the SHBP's effective administration; and

(9) to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student health insurance/benefits plan.

Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the SHBP.

The Plan Administrator will also have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as *Medical Necessity* or *Experimental or Investigational* treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the SHBP is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

Certificate of Creditable Coverage

As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the SHBP will provide a *Certificate of Coverage* to any *Covered Person* after the *Covered Student* loses coverage under the SHBP. In addition, a *Certificate* will be provided upon request, if the request is made within twenty-four (24) months after the *Covered Student* loses coverage under the SHBP. In that case, the *Certificate* will be provided at the earliest time that the SHBP, acting in a reasonable and prompt fashion, can furnish said *Certificate*.

Payment of Administrative Expenses

All reasonable costs incurred in the administration of the SHBP including, but not limited to, administrative fees and expenses owed to any third-party administrative service, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the *Plan Sponsor* unless the Plan Administrator directs the SHBP to pay such expenses and such payment by the SHBP is permitted by law.

Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other entity or person will incur any liability for any acts or failure to act.

Amendment

The Plan Administrator has the right to amend this SHBP. Any such amendment will be by a written instrument signed by a duly-authorized Officer of the *Plan Sponsor*. The Plan Administrator will notify Covered Persons of any amendment modifying the material terms of the SHBP no less than 60 days prior to the effective date of the amendment.

Termination of SHBP

Regardless of any other provision of the SHBP, the *Plan Sponsor* reserves the right to terminate the SHBP at any time without prior notice. Such termination will be evidenced by a written resolution of the *Plan Sponsor*. The Plan Administrator will provide notice of the SHBP's termination as soon as administratively feasible.

Assignment of Benefits

All benefits payable by the SHBP may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the SHBP's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

Alternate Payees

Generally, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the SHBP may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The SHBP must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a qualified medical child support order (QMCSO) or state *Medicaid* law.

The SHBP may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the SHBP.

Any payment made by the SHBP in accordance with this provision will fully release the SHBP of its liability to you.

Necessary Information

When you request benefits, you must furnish all the information required to implement plan provisions. Your signature on the claim form permits Princeton Theological Seminary to release or obtain information without your further authorization. The SHBP may, without further authorization or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions. The SHBP's privacy practices are described in the Health Service Notice on Privacy Practices.

Regulation of the SHBP

The SHBP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), No Surprises Act, and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the SHBP.

As a partially self-funded health plan, the SHBP is not regulated by the State of New Jersey's Department of Banking and Insurance.

The SHBP federal laws and regulations, including but not limited to:

- Title IX of the Education Amendments of 1972. The SHBP provides pregnancy benefits on the same basis as any other temporary disability pursuant to the requirements of Title IX of the Education Amendments of 1972.
- Section 504 of the Rehabilitation Act of 1973
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (refer to the Privacy Notice in the Student Health Program brochure).
- Regulations of the United States Information Agency that are applicable to VISA recipients.

The SHBP fully complies with the benefit requirements mandated in regulations for fully insured student health insurance plans issued by the U.S. Department of Health and Human Services (refer to Federal Register 77 FR 16453) and the State of New Jersey's Essential Health Benefits Benchmark Plan.

Plan Funding
All benefits paid under the SHBP shall be paid in cash from the designated SHBP fund established and maintained by the *Plan Sponsor*. No person shall have any right or title to, or interest in, any investment reserves, accounts, or funds that the *Plan Sponsor* may purchase, establish, or accumulate to aid in providing benefits under the SHBP. No person shall acquire any interest greater than that of an unsecured creditor.

Waiver and Estoppel
No term, condition, or provision of the SHBP shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the SHBP, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No *Covered Person* or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

Non-Vested Benefits
Nothing in the SHBP shall be construed as creating any vested rights to benefits in favor of any *Covered Person.*

Interests Not Transferable
The interests of the *Covered Student* and their *Eligible Dependents* under the SHBP are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

Severability
If any provision of the SHBP shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the SHBP, but the SHBP shall be construed and enforced as if the invalid or illegal provision had never been inserted. The *Plan Sponsor* shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the SHBP.

Headings
All Section headings in this Plan Document have been inserted for convenience only and shall not determine the meaning of the content thereof.

In General
Any and all rights provided to any *Covered Person* under the SHBP shall be subject to the terms and conditions of the SHBP. This Plan Document shall not constitute a contract between the *Plan Sponsor* and any *Covered Person,* nor shall it be consideration or an inducement for the initial or continued enrollment of any *Student* in the *Plan Sponsor*. Likewise, maintenance of this SHBP shall not be construed to give any *Covered Person* the right to be retained as a *Covered Person* by the *Plan Sponsor* or the right to any benefits not specifically provided by the SHBP.

Submission of Claims

How a *Covered Person* files a claim for benefits depends on the type of claim. There are several categories of benefits.

(1) Concurrent Care Claim – A claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

(2) Pre-Service Care Claim – A claim for a benefit under the SHBP with respect to which the terms of the SHBP require approval (usually referred to as *Precertification*) of the benefit in advance of obtaining medical care.

(3) Post-Service Care Claim – A claim for a benefit under the SHBP that is not a pre-service claim.

(4) *Urgent Care* Claim – An *Urgent Care* claim is a claim for medical care or treatment where a delay in deciding the claim:

(a) could seriously jeopardize the life or health of the *Covered Person* or the ability of the *Covered Person* to regain maximum function; or

(b) would subject the *Covered Person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim in the opinion of a *Health Care Provider* with knowledge of the *Covered Person's* medical condition.

A *Covered Person* may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, by himself or herself, by his or her authorized representative, or by his or her health care service *Health Care Provider*. Any of these types of claims must be filed using a written form supplied by the Claims Administrator and must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

If a *Covered Person's* claim involves *Urgent Care*, a *Covered Person* may initiate a claim for *Urgent Care* benefits for himself or herself if he or she is able, or his or her authorized representative, or treating *Health Care Provider* may file the claim for him or her. The claim must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

A *Covered Person* may file any claim himself or herself, or he or she may designate another person as his or her authorized representative by notifying the Claims Administrator in writing of his or her designation. In that case, all subsequent notices will be provided to the *Covered Person* through his or her authorized representative and decisions concerning that claim will be provided through his or her authorized representative.

The Claims Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing. **A *Covered Person* must submit a claim for benefits within 12 months after the date of service.** The completed form (and all invoices pertaining to services received if applicable) must be sent to the Claims Administrator at the following address:

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115
Electronic Payer Identification Number: 87843

If an *Out-of-Network Health Care Provider* submits a claim on a *Covered Person*'s behalf, the *Covered Person* will be responsible for the timeliness of the submission. If the *Covered Person* does not provide this information to the Claims Administrator within **12 months** of the date of service, benefits for that health service will be denied or reduced, at the Plan Administrator's discretion. This time limit does not apply if the *Covered Person* is legally incapacitated. If a *Covered Person's* claim relates to an *Inpatient* stay, the date of service is the date the *Covered Person's Inpatient* stay ends. If a *Covered Person* provides written authorization to allow direct payment to *Health Care Provider(s)*, all, or a portion of any *Covered Expenses* due to a *Health Care Provider,* may be paid directly to the *Health Care Provider* instead of being paid to the *Covered Person*. The SHBP will not reimburse third parties who have purchased or been assigned benefits by *Health Care Provider(s)*.

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. The Plan Administrator has delegated the administration of claims processing under the SHBP to the Claims Administrator. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the SHBP as they apply to the claims. In any case, a *Covered Person* will receive only those benefits under the SHBP that the Plan Administrator or an *Independent Review Organization* (*IRO*) determines he or she is entitled to receive. Refer also to subsection B, Inquiry, Grievance, and Appeals Process.

If the *Covered Person's* claim involves *Urgent Care*, the *Covered Person* or his or her authorized representative will be notified of the SHBP's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, a *Covered Person* or his or her representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. A *Covered Person* will have at least 48 hours to respond to this request. The Claims Administrator then must inform him or her of its decision within 48 hours of receiving the additional information.

If a *Covered Person's* claim is one involving concurrent care, the Claims Administrator will notify the *Covered Person* of its decision, whether adverse or not, within 24 hours after receiving the claim. The *Covered Person* will be given time to provide any additional information required to reach a decision.

If the *Covered Person's* claim is for a pre-service authorization, the Claims Administrator will notify him or her of its initial determination, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional fifteen (15) days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least forty-five (45) days to provide any additional information requested of the *Covered Person* by the Claims Administrator.

If the *Covered Person* has filed a post-service claim for reimbursement of medical care services that already have been rendered, the *Covered Person* will be notified of the Claims Administrator's decision on the *Covered Person's* claim only if it is denied in whole or in part. This notification will be issued no more than thirty (30) days after the Claims Administrator receives the claim. The Claims Administrator may extend this 30-day period once for up to fifteen (15) days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least forty-five (45) days to provide any additional information requested of the *Covered Person* by the Claims Administrator, if the need for the extension is due to the Claim Administrator's need for additional information from the *Covered Person* or his or her health care *Provider*s.

Inquiry, Grievance and Appeals Process

If you have not received an *Adverse Determination*, denial of benefits, or have a complaint, you must first submit an *Inquiry* to the Claims Administrator. In other words, you are only seeking to obtain information and or make a first attempt to resolve a concern through an *Internal Inquiry Process*. The Claims Administrator has three (3) business days to answer your *Inquiry* or attempt to resolve your concerns. If you are not satisfied with the response of the Claims Administrator, you may proceed with the *Grievance* process described in this Section.

First Level Internal Grievance

If you have received an *Adverse Determination*, denial of benefits, have a complaint or if you are not satisfied with the outcome of an *Inquiry* submitted through the *Internal Inquiry Process*, you or a *Health Care Provider* acting on your behalf, may file a *Grievance* with the Claims Administrator, within one hundred eighty (180) days, requesting a first level review of the *Adverse Determination*. The request may be by telephone, in person, by mail or by electronic means. Any oral *Grievance* made by you will be reduced to writing by the Claims Administrator and a copy will be forwarded to you within 48 hours or receipt.

Within three (3) working days or receipt of your *Grievance*, the Claims Administrator will provide you with the name, address and telephone number of the person or organization designated to coordinate the first level. The reviewers will take into consideration all comments, documents, and other information regarding the request for services submitted by you. You are entitled to provide additional written comments, documents, records and other materials relating to the request for benefits for the reviewers to consider when conducting their review. You are also entitled to receive from the Claims Administrator, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to you request for benefits as well as any new or additional rationale for denial and a reasonable opportunity for you to respond to such new evidence or rationale.

The Claims Administrator will issue a decision to you within the time frames provided below:

(a) With respect to a *Grievance* requesting a first level review of an *Adverse Determination* involving a prospective review request, the Claims Administrator shall notify and issue a decision within a reasonable period of time that is appropriate given your medical condition, but no later than thirty (30) days after the date of its receipt of the *Grievance* requesting the first level review.

(b) With respect to a *Grievance* requesting a first level review of an *Adverse Determination* involving a retrospective review request, the Claims Administrator shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of its receipt of the *Grievance* requesting the first level review.

(c) With respect to a *Grievance* that does not involve an *Adverse Determination*; the Claims Administrator shall issue a decision within twenty (20) days after the date of its receipt of the *Grievance* requesting a review.

If you appeal, the Claims Administrator will review its decision, as well as any additional comments, documentation, records, and other information submitted by you, and provide you with a written determination. If the Claims Administrator continues to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Refer to the Section below in entitled External Review.

Second Level Internal Grievance
It is your option, if you are not satisfied with the Seminary's First Level Internal Grievance decision, to have an additional review. You or your authorized representative may request a Second Level Internal Grievance review within forty-five (45) days from receipt of the decision by following the steps outlined above for the First Level Internal Grievance.

Your request will be reviewed by a panel, appointed by the Plan Administrator, which shall consist of individuals who were not involved in the first level review decision and shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by you or your authorized representative. You have the right to appear before this panel at the review meeting which will be held within forty-five (45) working days of the receipt of your request. You will be notified at least fifteen (15) working days prior to the date of the review meeting. A written decision will be issued to you within five (5) working days of completing the review.

Expedited Internal Grievance
You or your authorized representative may make a request, either orally or in writing, for an expedited internal review of an *Urgent Care Adverse Determination* involving an admission, availability of care, continued stay or if you have received *Emergency Medical Services* but have not been discharged from a facility. An expedited review decision will be made, and you will be notified of the decision as soon as possible but in no event more than 24 hours after receipt of the request for expedited review.

If the Grievance involves an *Adverse Determination* with respect to a concurrent review urgent care request, the service(s) in question will be continued until you have been notified of the Claims Administrator's determination.

External Review
You may request an External Review once you have exhausted the Internal Grievance process or if you have elected not to pursue the Second Level Internal Grievance process. You shall be considered to have exhausted the internal Grievance process, if you:

(a) have filed a *Grievance* involving an *Adverse Determination*; and

(b) except to the extent that you requested or agreed to a delay, have not received a written decision on the *Grievance* from the Claims Administrator within thirty (30) days following the date you filed the *Grievance* with the Claims Administrator.

Standard External Review
Under the *Plan Sponsor*'s compliance with the Patient Protection and Affordable Care Act (PPACA), a request to the Commissioner of Insurance for the State of New Jersey is not necessary.

Within five (5) business days following receipt of the external review request, the Claims Administrator shall complete a preliminary review of the request to determine whether:

(a) you are or were a covered person at the time the health care service was requested or provided;
(b) the health care service that is the subject of the *Adverse Determination* is a covered service under your health benefit plan, but is not covered because it does not meet requirements for *Medical Necessity,* appropriateness, health care setting, level of care or effectiveness;
(c) you have exhausted the internal *Grievance* process; and
(d) you have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Administrator shall notify you and the Plan Administrator in writing whether the request is complete and eligible for external review.

If the request is not complete, the Claims Administrator will inform you and the Plan Administrator in writing and include what information or materials are needed to make the request complete. If the request is not eligible for external review, the Claims Administrator will notify you and the Plan Administrator in writing and include in the notice the reasons for its ineligibility. If you are not satisfied with this reply, an *IRO* will be asked to review your *Grievance*.

Upon your receipt of your request for review by an *IRO*, the Claims Administrator shall provide, within five (5) business days, the *IRO* with any documents and information considered in making the *Adverse Determination*. The Claims Administrator's failure to provide the documents and information within the time specified shall not delay the conduct of the external review. If the Claims Administrator fails to provide the documents and information within the time specified, the *IRO* may terminate the external review and make a decision to reverse the *Adverse Determination*. Within one (1) business day after making the decision, the *IRO* shall notify you, Claims Administrator, and the Plan Administrator.

The *IRO* shall review all of the information and documents received and any other information submitted in writing by you. Upon receipt of any information submitted by you, the *IRO* shall, within one (1) business day, forward the information to Claims Administrator. Upon receipt of the information, the Claims Administrator may reconsider its *Adverse Determination* that is the subject of the external review. Reconsideration by the Claims Administrator of its *Adverse Determination* or final *Adverse Determination* shall not delay or terminate the external review. The external review may be terminated only if the Claims Administrator decides, upon completion of its reconsideration, to reverse its *Adverse Determination* or final *Adverse Determination* and provide coverage or payment for the health care service that is the subject of the *Adverse Determination* or final *Adverse Determination*.

Within one (1) business day after making the decision to reverse Our Adverse Determination, the Claims Administrator shall notify you, the *IRO*, and the Plan Administrator in writing of its decision. The *IRO* shall terminate the external review upon receipt of the notice from Claims Administrator.

In addition to the documents and information provided, the *IRO* shall consider the following in reaching a decision:

(a) your medical records;
(b) the attending health care professional's recommendation;
(c) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, you, or your treating provider;
(d) the terms of coverage under your health benefit plan with the Claims Administrator to ensure that the *IRO*'s decision is not contrary to the terms of coverage under your health benefit plan with the Claims Administrator;
(e) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(f) any applicable clinical review criteria developed and used by Claims Administrator or its designee utilization review organization; and
(g) the opinion of the *IRO*'s clinical reviewer or reviewers after considering paragraphs (a) through (f) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Within forty-five (45) days after the date of receipt of the request for an external review, the *IRO* shall provide written notice of its decision to uphold or reverse the *Adverse Determination* or the final *Adverse Determination* to you, the Claims Administrator and the Plan Administrator.

The *IRO* shall include in the notice:

(a) a general description of the reason for the request for external review;
(b) the date the *IRO* was notified of the request for review by the Claims Administrator;
(c) the date the external review was conducted;
(d) the date of its decision;
(e) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;
(f) the rationale for its decision; and
(g) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

Upon receipt of a notice of a decision reversing the *Adverse Determination*, the Claims Administrator shall immediately approve the coverage that was the subject of the *Adverse Determination*.

Expedited External Review

You or your authorized representative may make a request for an expedited external review at the time you receive an *Adverse Determination* if:

1) the *Adverse Determination* involves a medical condition for which the time for completion of an expedited internal review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and

2) you have filed a request for an expedited review of a *Grievance* involving an *Adverse Determination if*:

   i. you have a medical condition where the time for completion of a standard external would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
   ii. the final *Adverse Determination* concerns admission, availability of care, continued stay or health care service for which you received *Emergency Medical Services*, but have not been discharged from a facility.

The Claims Administrator or designee utilization review organization shall provide to the *IRO* the documents and any information considered in making the *Adverse Determination*.

Within 72 hours after the date of receipt of the request, the *IRO* shall make a decision to uphold or reverse the *Adverse Determination*. After making their decision, the *IRO* shall notify you, or if applicable, your authorized representative or Claims Administrator. Immediately upon receipt of the notice of a decision reversing *the Adverse Determination*, the Claims Administrator shall approve the coverage that was the subject of *the Adverse Determination*.

The following terms define specific wording used in the SHBP. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of the SHBP.

Accident. means a sudden or unforeseen event which:

(2) causes *Injury* to the physical structure of the body;

(3) results from an external agent of trauma;

(4) is definite as to time and place; and

(4) may happen involuntarily and entail unforeseen consequences or may be the result of an intentional self-inflicted *Injury* and entail foreseeable consequences.

An Accident does not include harm resulting from a disease or sickness and will be determined by the Claims Administrator.

Adverse Determination. means:

(1) the requested benefit is denied, reduced, or terminated, or payment is not made, in whole or in part, for the benefit because a determination was made by the Claims Administrator that, based upon the information provided, the request for benefit under the SHBP does not meet the requirements for *Medical Necessity*, appropriateness, health care setting, level of care or effectiveness, or is determined to be *Experimental or Investigational*;

(2) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Claims Administrator of your ineligibility to participate in the SHBP;

(3) any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part for a benefit; or

(4) a rescission of coverage determination.

Annual Open Enrollment Period. Eligible students and their eligible dependents may enroll in the SHBP at the beginning of any *Plan Year*. Both new and returning eligible students may enroll in the SHBP during the fall open enrollment period, this includes students who have previously waived participation in the SHBP based on approved personal health insurance coverage.

The deadline for submission of SHBP enrollment forms is published in the Student Health Program brochure (and Student Health Program web site) for the fall semester *Annual Open Enrollment Period* for each *Plan Year*. Students who waive participation in the SHBP during the fall semester are not allowed to later enroll in the SHBP during the *Plan Year*, except as specifically provided Section IV, Eligibility and Participation, Late Enrollments.

For eligible students first enrolling at the Seminary following the fall semester *Annual Open Enrollment Period*, a limited period is allowed for enrolling in the SHBP or waiving SHBP coverage based on an approved personal health insurance program. These deadlines area published in the Student Health Program brochure for each period of coverage during the *Plan Year.* These enrollment deadlines are also available

at the Student Health Program web site: **Error! Hyperlink reference not valid.**https://inside.ptsem.edu/Community/Entering_ReturningStudents/Content.aspx

Aggregate Plan Year Deductible. Except as specifically provided for coverage that is subject to a *Copayment*, the *Aggregate Plan Year Deductible* is the amount of *Covered Expenses/Services* you must pay during each *Plan Year* before the SHBP will consider expenses for reimbursement.

Ambulatory Surgical Facility. A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *Physicians;* maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Birthing Center. A public or private facility, other than private offices or clinics of *Physicians*, which meets the free standing birthing center requirements of the State Department of Health in the state where the *Covered Person* receives the services.

The *Birthing Center* must provide: a facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a *Physician* or certified *Nurse* midwife at all births and immediate postpartum period; extended staff privileges to *Physicians* who practice obstetrics and gynecology in an area *Hospital*; at least 2 beds or 2 birthing rooms; full-time nursing services directed by an R.N. or certified *Nurse* midwife; arrangements for diagnostic X-ray and lab services; and the capacity to administer local anesthetic or to perform minor *surgery.*

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *Hospital* for emergency transfers and maintain medical records on each patient and child.

Chiropractic Services. The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Close Family Member (Family Member). The spouse, brother, sister, parent, child, uncle, or aunt of an *Covered Person*. For the purpose of Dependent Coverage, a family member is the spouse or child, adopted-child, stepchild, or foster-child of living with the *Covered student*.

Copayment. A *Copayment* is the amount of *Covered Expenses/Services* you must pay before the SHBP will consider expenses for reimbursement under the Schedule of Medical Expense Benefits or Schedule of Prescription Drug Benefits provided in this Plan Document. Unless otherwise specified, *Copayments* may not be used to satisfy the *Deductible*.

Coinsurance. The percentage of *Covered Expenses/Services* to be paid by the SHBP and the *Covered Person* after satisfaction of the *Aggregate Plan Year Deductible* or *Copayment*. These percentages apply only to *Covered Expenses/Services* which do not exceed *Reasonable and Customary Charge*s. The *Covered Person* is responsible for all non-*Covered Expenses/Services* and any amount which exceeds the *Reasonable and Customary Charge* for *Covered Expenses/Services*

Cosmetic Surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to a *Sickness* or *Injury.*

Covered Expense(s)/Service(s): A health service or supply that is eligible for benefits when performed by a *Provider* or *Physician.* A *Covered Expenses/Services* must be a medical expense charge that is specifically identified in this Plan Document as being covered by the SHBP and not otherwise excluded by the SHBP.

Covered Person(s)*:* A person who is eligible for coverage under the SHBP and is covered by the SHBP following the full payment of the applicable cost of coverage.

Custodial Care. Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *Health Care Provider.*

Diagnostic Charges. The *Medically Necessary* charges for X-ray or laboratory examinations made or ordered by a *Physician or Health Care Provider* in order to detect a medical condition.

Durable Medical Equipment. Equipment able to withstand repeated use for the therapeutic treatment of an active *Sickness* or *Injury.* Such equipment will not be covered under the SHBP if it could be useful to a person in the absence of a *Sickness* or *Injury* and could be purchased without a *Physician's* prescription.

Essential Benefits/Services. For the purposes of considering a request for extension of the maximum 90 day period under the provision for extension of SHBP eligibility due to an Approved Medical Withdrawal, a *Medically Necessary* service or supply that could not be reasonably be provided by a health care provider that is covered by a health insurance that replaces the SHBP with similarly expected medical outcomes, convenience for access to care for the patient, continuity of care, or other factor for care, that, in the sole judgment of the Plan Administrator, appropriately necessitates the continuation of SHBP eligibility under the provisions for an Approved Medical Withdrawal.

Emergency/Emergency Care/Emergency Medical Condition. Means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Examples of emergency care situations include, but are not limited to, symptoms of heart attack and stroke, poisoning, loss of consciousness, loss of breath, shock, severe bleeding, or convulsions. Emergency care does not include ambulance service to the facility where treatment is received (see Ambulance Services in Section VI: Schedule of Medical Benefits).

Emergency Medical Services. Means, with respect to an *Emergency Medical Condition*:

(1) a medical screening examination that is within the capability of the emergency department of a *Hospital*, including services routinely available to the emergency department, to evaluate such *Emergency Medical Conditions*; and

(2) such additional medical examination and treatment necessary to stabilize a patient.

Experimental or Investigational. Services, including but not limited to transplants, which are educational in nature or any treatment (including pharmacological regimes) that are not recognized as generally accepted medical practice by the medical profession. Criteria for determining whether or not a procedure or

treatment will be considered *Experimental* or *Investigational* will include, but not be limited to, the following:

- Whether the service has final approval from the appropriate government regulatory bodies (FDA, or other regulatory authority as appropriate).
- Whether the procedure or treatment is generally accepted by the medical profession.
- Whether the scientific evidence permits conclusions concerning the effect of the service on health outcomes, and whether, in the predominant opinion of the experts, as expressed in the published authoritative literature, that (I) usage should be substantially confined to research settings, or (ii) that further research is necessary, or the written protocol describes among its main objectives the necessity, to determine safety, toxicity, efficacy, or effectiveness of that service compared with conventional treatment alternatives.
- Whether the service is being delivered or should be delivered subject to the approval and supervision of an institutional review board as required and defined by federal regulations, particularly those of the Food and Drug Administration or the Department of Health and Human Services.
- The failure rate and side effects of the treatment or procedure.
- Whether other, more conventional methods of treatment have been exhausted.
- Whether the service is as beneficial as any established alternatives.
- Whether the procedure or treatment is *Medically Necessary* and is expected to improve the net health outcome of the covered individual.
- Whether the procedure or treatment is recognized for reimbursement by *Medicare*, *Medicaid*, other insurers or self-funded plans, or other applicable third party payers.
- Whether the procedure or treatment is a complication of an *Experimental or Investigational* service.

Procedures in question for their *Experimental or Investigational* nature will be reviewed by appropriate members of the medical profession for recommendation. To be covered, the procedure or treatment in question must not be determined to be *Experimental or Investigational* and the covered individual must meet the criteria for treatment or other procedure with regard to age, general health, etc., and have been determined to be a good candidate for the procedure or treatment by an accredited facility. Final decisions regarding coverage under the SHBP will be at the sole discretion of the SHBP *Claims Administrator*.

Gender Dysphoria – means a condition in which there is a marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-5). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender reassignment, which can involve genital reconstruction surgery and breast/chest surgery. For the Ft. patient, surgical procedures may include mastectomy, hysterectomy, sapling-oophorectomy, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, placement of testicular and/or penile prostheses and phalloplasty or metoidioplasty (alternative to phalloplasty). For the Miff patient, surgical procedures may include penectomy, vaginoplasty, chloroplast, labiaplasty, orchiectomy and urethroplasty.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

Grievance – means a written or oral complaint submitted by you, or on your behalf, regarding:

(1) availability, delivery or quality of health care services, including a complaint regarding an *Adverse Determination*; or

(2) claims payment, handling or reimbursement for health care services; or

(3) matters pertaining to the relationship between you and the Claims Administrator.

Health Care Provider*(s).* A *Physician, nurse, Hospital or Specialized Treatment Facility* as those terms are specifically defined in this Section. A health care provider must not be spouse, child, or other *Close Family Member* of the *Covered Person* receiving services.

Health Care Provider includes, but is not limited: a *Physician*, Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified *Nurse* Midwife (C.N.M.), Certified Registered *Nurse* Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph. D., Ed. D., Posy. D., MA), Registered *Nurse* (R.N.), *Nurse* Practitioner (A.R.N.P.), Certified Diabetes Educator, Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist, *Physician*'s Assistant, Registered Respiratory Therapist, Nutritionist, Naturopath (N.D.) or Pastoral Counselor. Spiritual Directors as designated by Princeton Theological Seminary will be treated as health care providers.

Home Health Care Agency. A public or private agency or organization licensed and operated according to the law that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one *Physician* and one registered graduate *Nurse* to supervise the services provided.

Hospice (Home Hospice). A program, licensed and operated according to state law, which is approved by the attending *Physician* to provide palliative, supportive and other related care in the home for a terminally ill *Covered Person*.

Hospice Facility. A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other *related fare* for an *Covered Person* diagnosed as terminally ill. The facility must have an inter-disciplinary medical team consisting of at least one *Physician,* one registered *nurse*, one social worker, one volunteer and a volunteer program.

A *Hospice Facility* is not a facility or part thereof which is primarily a place for rest, *Custodial Care,* the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital. A public or private facility licensed and operated according to the law, which provides care and treatment by *Physicians* and *nurses* at the patient's expense of a *Sickness* or *Injury* through medical, surgical and diagnostic facilities on its premises.

A *Hospital* does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged or convalescent care.

Injury. A condition which results independently of a *Sickness* and all other causes and is a result of an externally violent force or *accident.*

In-Network (In-Network Provider). *Physicians* and other *Health Care Providers* in the *Princeton Area* who have contracted with the SHBP to provide specific medical care at negotiated prices or a *Preferred Allowance* are referred to collectively as *In-Network Provider*s. Outside of the *Princeton Area*, the SHBP has contracted with the managed care network identified in the Schedule of Medical Benefits to provide *In-Network* services.

Under the following circumstances, the higher In-Network benefit level may be available for certain Out-of-Network Healthcare Provider's services:

- Professional services of an emergency room Physician, radiologist, pathologist or anesthesiologist when services are rendered in an In-Network facility.
- Services not available by an In-Network Provider.
- Covered Individuals who are traveling or reside outside of *Princeton Area* and an In-Network Provider is more than 30 miles from the location where the student is able to obtain care.
- Treatment for *Emergency Medical Services*.

Charges made by an *Out-of-Network Provider* may exceed the *Reasonable and Customary Charge* amount for such procedures and a Covered Person may be balance billed for the difference. A *Covered Person* will not be balance billed for procedures performed by an In-Network Provider in excess of the In-Network Provider fee schedule.

Inpatient. Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit. A section, ward or wing within a *Hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and cure by registered graduate *nurses* or other highly trained personnel. *Intensive Care Unit* does not include any *Hospital* facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Internal Inquiry Process. A process, prior to the Grievance process, during which the Claims Administrator attempts to answer and/or resolve concerns communicated by you or on your behalf. If the Claims Administrator fails to answer your questions or resolve your concerns to your satisfaction within three (3) business days, you have the option to proceed to the Internal Grievance Process provided in Section XVI, Procedures/Statement of Rights.

Legend Drug. *A Legend Drug* is any drug or medication designated as *"Rx Only"* by the Federal Food, Drug and Cosmetic Act, as amended. They cannot be dispensed without prescription.

Lifetime. The period of time your or your eligible dependents participate in the SHBP or any other *Plan Sponsor*ed by Princeton Theological Seminary for Princeton Theological Seminary students and/or their eligible dependents.

IRO. Means an Independent Review Organization. Refer to Section XVI, Procedures/Statement of Rights, Inquiry, Grievances, and Peals Process.

Wellfleet Rx Network Maximum Allowable Cost. The maximum amount that a pharmacy in the Wellfleet Rx Network will be reimbursed for a particular prescription drug.

Medicaid. Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medicare. Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Medical Necessity/Medically Necessary. A service or supply is Medically Necessary only when it meets all of the following requirements:

(1) It must be legal.

(2) It must be ordered by a Provider/Practitioner.

(3) It must be safe and effective in treating the condition for which it is ordered.

(4) It must be part of a course of treatment which is generally accepted by the American medical community. That community includes all of the branches, professional societies, and governmental agencies therein.

(5) It must be of the proper quantity, frequency, and duration for treatment of the condition for which it is ordered.

(6) It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered.

(7) It must not be *Experimental or Investigational*.

(8) Its purpose must be to restore health and extend life.

This determination may include the consideration of the findings and assessments of the following entities:

- the Office of Medical Application of Research of the National Institute of Health, the Office of Technology Assessment of the United States Congress, or any similar entities;
- national medical associations, societies, and organizations;
- the Federal Drug Administration; and/or
- the Plan Administrator's own medical and legal counsel and advisors.

Mental/Nervous Disorder. For purposes of the SHBP, a *Mental/Nervous Disorder* is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specifically excluded in Section IX, Medical Benefits, Medical Benefit Exclusions, for which treatment is commonly sought from a psychiatrist or mental health *Physician*. The DSM is a clinical

diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered *Mental/Nervous* in nature, regardless of etiology.

Mental/Nervous Treatment Facility. A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation and effective treatment of *Mental/Nervous Disorders*; and professional nursing services provided by licensed practical *nurses* who are directed by a full-time R.N. The facility must have a *Physician* on staff or on call.

The facility must also prepare and maintain a written plan of treatment for each patient. The SHBP must be based on medical, psychological and social needs.

Nurse. A person acting within the scope of applicable state licensure/certification requirements and holding the degree of Registered Graduate *Nurse* (R.N.) or Licensed Practical *Nurse* (L.P.N.).

Oral Surgery. Necessary procedures for *surgery in the oral cavity,* including pre- and postoperative care.

Outpatient. Treatment either outside of a *Hospital* setting or at a *Hospital* when room and board charges are not incurred.

Out-of-Network Providers. *Providers* that are not *In-Network Providers*.

***Partial Hospitalizatio*n**. A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a *mental/nervous disorder* when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Partial Hospitalization programs must provide diagnostic services; services of social workers; psychiatric *Nurse*s and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the *Partial Hospitalization* must prepare and maintain a written plan of treatment for each patient. The SHBP must be approved and periodically reviewed by a *Physician*.

Physician. A licensed Doctor of Medicine or Doctor of Osteopathy practicing within the scope of their license and who is not a *Close Family Member* of the *Covered Person* receiving services.

Physically or Mentally Disabled. The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *Physician* as a permanent and continuing condition.

Plan Administrator. Princeton Theological Seminary, is the sole fiduciary of the SHBP, and exercises all discretionary authority and control over the administration of the SHBP and the management and disposition of plan assets. The *Plan Administrator* shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the SHBP. The *Plan Administrator* has the right to amend, modify or terminate the SHBP in any manner, at any time, regardless of the health status of any plan participant or beneficiary.

The *Plan Administrator* may retain a firm to perform claims processing and other specified services in relation to the SHBP. Any such contractor will not be a fiduciary of the SHBP and will not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*, as described above.

Plan Sponsor. Princeton Theological Seminary for Princeton Theological Seminary students and/or their eligible dependents.

Plan Year. The 12-month fiscal period beginning September 1 and ending August 31.

***Preferred Allowanc*e**. The amount that payment is based on for given *Covered Expenses/Services* to an *In-Network Provider* who/which has entered into an agreement with the *Plan Administrator* to be an *In-Network Provider* for the SHBP.

Princeton Area. *Princeton Area* refers to the zip code geographic areas within Mercer County.

Provider(s)/Practitioners. Refer to definitions *Health Care Providers* and *Physician*.

Psychiatric Day Treatment Facility. A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than 8 hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *Physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Reasonable and Customary Charge – A charge both Reasonable and Customary based on the following determinations by the Claims Administrator for charges submitted by Out-of-Network *Providers/Practitioners*.

(1) Reasonable – the amount which is determined to be Reasonable based on the complexity of treatment of a particular case and the prevailing fee for such treatment in the geographic area where the service is provided (in unusual circumstances or cases with medical complications requiring additional time, skill, and experience in connection with a particular service or procedure, moderate variations from the prevailing fee may be permitted); and

(2) Customary – the amount which falls within the range of usual charges for a given service charged by most Provider(s)/Practitioner(s) with similar training and experience in a geographic area as determined by the Plan Administrator.

Reconstructive Surgery. A procedure performed to restore the anatomy and/or functions of the body, which are lost or impaired due to *Injury or Sickness*.

Rehabilitation Facility. A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *Hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post-acute *Hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *Custodial Care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *Mental/Nervous Disorders*, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a *Rehabilitation Facility* for the treatment of *Mental/Nervous Disorders* or substance abuse in the jurisdiction where it is located, 29 or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of *Rehabilitation Facilities*.

Residential Treatment Facility. A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a *Residential Treatment Facility* by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

SHBP*:* The Student Health Benefits Plan explained in this Plan Document and provided by Princeton Theological Seminary.

Second Surgical Opinion. Examination by a *Physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *Surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Sickness. Any bodily *Sickness* or *Mental/Nervous Disorder.* For purposes of the SHBP, pregnancy will be considered as any other *Sickness.*

Skilled Nursing Facility. A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered *Nurse* or *Physician* on full-time duty in charge of patient care; at least one registered *Nurse* or licensed practical *Nurse* on duty at all times; a daily medical record for each patient; transfer arrangements with a *Hospital*; and a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *Sickness or Injury*, and is not, other than by coincidence, a rest home for *Custodial Care* or for the aged.

Specialized Treatment Facility. A *Specialized Treatment Facility*, as the term relates to the SHBP, includes *Birthing Centers, Ambulatory Surgical Facilities, Hospice Facilities, Skilled Nursing Facilities, Mental/Nervous Treatment Facilities, Substance Abuse Day Treatment Facilities*, *Psychiatric Day Treatment Facilities, Substance Abuse Treatment Facilities*, and *Rehabilitation Facilities* as those terms are specifically listed as Covered Expenses/Services.

Substance Abuse Treatment Facility. A public or private facility, licensed and operated according to the law and accredited by the Joint Commission on the Accreditation of Hospitals, which provides a program for diagnosis, evaluation and effective treatment of substance abuse, detoxification services and professional nursing care provided by licensed practical *Nurse*s who are directed by a full-time R.N. The facility must have a *Physician* on staff or on call.

The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological and social needs.

Surgery. Any operative or diagnostic procedure performed in the treatment of an *Injury or Sickness* by instrument or cutting procedure through any natural body opening or incision.

Total Disability (Totally Disabled). An individual will be considered *Totally Disabled* if, because of a non-occupational *Injury or Sickness*, he or she is prevented from engaging in all the normal activities of a person of like age who is in good health. Refer also to the definition of *Physically or Mentally Disabled*.

Medical Evacuation and Repatriation Coverage

The Plan Sponsor provides Medical Evacuation and Repatriation Coverage through a separate fully insured policy for students and dependents covered by the SHBP. Refer to the Section entitled General Information in this Plan Document for the name of the vendor providing this coverage and the vendor's website.

To the extent the fully insured coverage specified above does not provide benefits for Medical Evacuation charges that would otherwise constitute *Coved Expenses/Services* under the SHBP, and to the extent such charges are *Medically Necessary*, the SHBP will provide funding for such benefits. In most instances, the vendor specified above will continue to coordinate and/or provide the Medical Evacuation services and the funding for the cost of the services will be paid by the SHBP under this provision.