PLAN DOCUMENT
FOR THE
STUDENT HEALTH BENEFITS PLAN (SHBP)

EFFECTIVE DATE: SEPTEMBER 1, 2014

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

https://our.ptsem.edu/ics/Campus_Life/Health_Resources.jnz
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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.
ESTABLISHMENT OF SHBP

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 There are no unpublished Plan provisions.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 2014-2015 Plan Year, as described herein, is revised effective September 1, 2014, 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: ______________________________

Authorized Signature

Date ____________________________

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.

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 Students 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 Sponsored 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: HealthSmart, 800-331-1036. 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.phcs.com](http://www.phcs.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.

Please note there are no preadmission or precertification of care requirements under the SHBP, however, all services must be Medically Necessary and must be Covered Expense/Service that is not limited or excluded in this Plan Document.

(2) **Outpatient surgery**

If appropriate, consider having Surgery performed in the outpatient department of the Hospital, a surgical care center, or a Health Care Provider’s office. This will eliminate the Hospital room and board charges as well as overnight stays.

(3) **Generic Medications**

A generic drug is a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. Whenever possible, request that your Health Care Provider(s) prescribe a generic drug if it is the lowest cost option.

(4) **Patient and Protection Affordable Care Act (PPACA)**

The Seminary configured the SHBP to voluntarily comply 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: PPACA Required Care Benefits, and Section XVI, Procedures/Statement of Rights.
**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, 2014  
Originally effective September 1, 2005.

**Plan Sponsor**  
Princeton Theological Seminary  
64 Mercer Street,  
Princeton, New Jersey 08542-0803

**Group Number**  
SH448

**Plan Administrator**  
Director of Admissions and Financial Aid  
Princeton Theological Seminary  
64 Mercer Street  
P.O. Box 821  
Princeton, NJ 08542-0803  
matt.spina@ptsem.edu  
609-497-7805

**Claims Administrator**  
(refer to Section XVI, Procedures/Statement of Rights, for claims submission instructions)  
HealthSmart Benefit Solutions (formerly Klais & Company)  
3320 West Market Street, Suite 100,  
Fairlawn, OH 44333  
www.klais.com  
800-331-1096

**In-Network Providers**  
Private Healthcare Systems/Multiplan  
www.phcs.com or MultiPlan

In-Network Providers directly contracted by the Plan Sponsor for the SHBP:

- Princeton University Medical Center
- Trinity Counseling Service
- Specialty Counseling Network

**Prescription Benefit Administrator**  
HealthSmart Rx  
www.healthsmart.com  
800-681-6912

**Case Management Services**  
HealthSmart (formerly Klais & Company, Inc.)

**Medical Evacuation and Repatriation Provider**  
FrontierMEDEX Travel Assistance  
North America: 800-527-0218  
Foreign Countries: 410-453-6330 (collect calls)
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 consent of any Covered Person is not required to terminate or change 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 enrolled at Princeton Theological Seminary if enrollment occurs pursuant to the Annual Open Enrollment Period requirements for the SHBP.
- 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;
- An unmarried child younger up to age 26.
- A Physically or Mentally Disabled Child of any age, provided the disability began before he or she reached 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 living in your home;
- A foster child if he or she lives with you and is dependent upon you for support and maintenance.
- 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. 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 Admissions and Financial Aid 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 do 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.

**When Coverage Ends**
Your coverage will end for you and your covered dependents on the earliest of the following dates:
• Except as specifically provided for in Approved Medical Withdrawal, on the date you withdraw from the Seminary and are no longer eligible to participate in the SHBP as specified in Student Eligibility.

• August 31st, if you waive coverage for the next Plan Year.

• 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.

• The date you enter into the armed services of any country. A pro-rated refund of the SHBP cost will be provided. NO OTHER SHBP COST REFUNDS WILL BE ISSUED.

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 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.

The coverage of any Covered Person shall automatically cease immediately upon the earliest day indicated below:
Approved Medical Withdrawal

Any Student enrolled in the SHBP, who, as a result of an Injury or Illness, is Totally Disabled, will be eligible to continue coverage under the SHBP for himself/herself (and for his/her SHBP-Covered Dependents who are enrolled in the SHBP at the time the medical leave commences) for a period not to exceed 90 days following the date of an Approved Medical Withdrawal, expect as specifically provided in this Section. Coverage under the SHBP will continue during the maximum 90 day period until the date coverage becomes effective under other health insurance purchased by the Student. The 90 day coverage period resulting from an Approved Medical Withdrawal is subject to the approval of the Plan Administrator, including a determination by the Plan Administrator that the Student (or his or her representatives) made a good faith effort to obtain health insurance under a state of federal insurance exchange.

The Student, or his or representative, may submit a request to the Plan Administrator to have eligibility for the SHBP continued until the end of the Plan Year, or the date the Student is no longer Totally Disabled and/or returns to the Seminary, whichever is earlier. The request for Extension of Eligibility beyond the maximum 90 day period under the Approved Medical Withdrawal must be based on the Student either (1) not having eligibility to enroll in a health insurance plan provided by a state or federal insurance exchange following withdrawal from the Seminary and loss of SHBP eligibility; or (2) the insurance exchange coverage that would replace the SHBP does not provide either Essential Benefits/Services or coverage, either in-network or out-of-network, for a health care provider that is rendering Essential Services to the Student. In no event will coverage for the SHBP extend beyond the end of the Plan Year in which the Student has a Approved Medical Withdrawal from the Seminary.

Certification of the Approved Medical Withdrawal must be made by the Student’s Provider/Practitioner and such certification must be presented to and approved by the Plan Administrator. The Approved Medical Withdrawal cannot extend beyond end of the Plan Year in which the Approved Medical Withdrawal is granted. Refer also to Termination Events for international Students who leave the United States.
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 no employer and employee relationship between Princeton Theological Seminary 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 the Schedule of Prescription Benefits.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coinsurance Amount (What the SHBP Pays)</th>
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<tbody>
<tr>
<td><strong>In-Network</strong></td>
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<tr>
<td>Princeton Area</td>
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</tr>
<tr>
<td>• Physicians: Private Health Care Systems/Multiplan (<a href="http://www.PHCS.org">www.PHCS.org</a>)</td>
<td></td>
</tr>
<tr>
<td>• Hospital: University Medical Center at Princeton</td>
<td></td>
</tr>
<tr>
<td>• Trinity Counseling Service</td>
<td></td>
</tr>
<tr>
<td>• Specialty Counseling Network</td>
<td></td>
</tr>
<tr>
<td><strong>Outside Princeton Area</strong></td>
<td></td>
</tr>
<tr>
<td>Private Health Care Systems (<a href="http://www.PHCS.org">www.PHCS.org</a>)</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
</tr>
</tbody>
</table>

**Aggregate Plan Year Deductible**

- Individual: $0
- Family: $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.

- Individual: $250
- Family: $750

Unless otherwise specified, all services are subject to the Aggregate Plan Year Deductible.

**Plan Year Out-of-Pocket Maximum**

- Individual: $3,500
- Family: $7,000

- Individual: $7,750
- Family: $23,250

Deductibles and all Copayments, including Copayments for prescription drugs, may be used to satisfy the Plan Year Out-of-Pocket Maximum.

**Lifetime Individual Maximum for All Benefits**

- Unlimited

Includes all other maximums and prescription drug benefits.

**Preventive Services**

- Preventive care services are covered in compliance with the Patient Protection and Affordable Care Act (PPACA)

- Certain other preventive care services are 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.

- $0 Copayment/$0 Coinsurance.
- $0 Copayment/$0 Coinsurance.

Not Covered

Refer to Section VIII, PPACA Required Benefits
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coinsurance Amount (What the SHBP Pays)</th>
<th>In-Network</th>
<th>Outside Princeton Area</th>
<th>Out-of-Network</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Office Visits (includes visits to Registered Dieticians) (Sickness, Injury, or Preventive Services for Children)</td>
<td>$35 copayment per visit and 100% of Preferred Allowance thereafter. Ancillary expenses, other than surgical procedures, such as laboratory and X-ray that are billed by the Physician’s office are also covered at 100% of the Preferred Allowance. Surgical services are limited to a maximum benefit of $100, thereafter the separate Outpatient/Ambulatory Surgery benefit applies to surgical charges in excess of $100</td>
<td>Same as Princeton Area In-Network Benefits</td>
<td>Covered under Physicians Services</td>
<td></td>
<td>Refer to Special Provisions for Wellness benefits for children. This Copayment may not be used to satisfy the Aggregate Plan Year Deductible.</td>
</tr>
<tr>
<td>Surgeon’s Fees</td>
<td>$100 Copayment per surgical procedures and 80% of Preferred Allowance. The copayment is not charged for the first $100 of surgical charges billed by a physician for surgical procedure performed during an office visit.</td>
<td>Same as Princeton Area In-Network Benefits</td>
<td>75% of Reasonable and Customary allowance</td>
<td></td>
<td>Multiple Copayments are not charged for multiple surgeries performed during the same operating session.</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$100 per visit Co-payment, 100% and</td>
<td>Same as Princeton Area</td>
<td>Same as Princeton Area</td>
<td></td>
<td>This Copayment may not be used to satisfy the Aggregate Plan Year Deductible.</td>
</tr>
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# Schedule of Medical Benefits

## Section VI

<table>
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<th>Service</th>
<th>Benefit Description</th>
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<tr>
<td><strong>Preferred Allowance</strong></td>
<td>Preferred Allowance for expenses incurred at Emergency Department of the University Medical Center at Princeton. This benefit includes all charges incurred in the Emergency Department, including Physician charges, and ancillary services for laboratory and X-ray.</td>
</tr>
<tr>
<td><strong>In-Network Benefits</strong></td>
<td>In-Network Benefits, subject to Reasonable and Customary allowance</td>
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<tr>
<td><strong>In-Network Benefits, subject to Reasonable and Customary allowance</strong></td>
<td>Covered only for an Emergency Medical Condition.</td>
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### Urgent, Non-Routine, After Hours Care

- Covered Same as Medical Office Visits
- 75% of Reasonable and Customary allowance
- Urgent care services at PHCS providers 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% of Preferred Allowance
- 75% 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)

### Maternity Services

- 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
- 75% 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
- 75% of Reasonable and Customary allowance

### Ambulance

- Not covered (there are no in-network providers in the Princeton area)
- $100 Copayment per trip and 80% of Preferred Allowance thereafter
- 75% of Reasonable and Customary allowance
- Refer to the separate emergency travel and assistance coverage for SHBP-Covered Persons for air ambulance benefits.

### Skilled Nursing Facility

- $0 Copayment and 80% of Preferred Allowance
- 80% of Preferred Allowance
- 75% of Reasonable and Customary allowance
- Subject to Medical Necessity determination by the SHBP Claims Administrator.
### Physical Therapy
$35 Copayment per visit when services are provided at University Medical Center of Princeton facilities.
80% of Preferred Allowance
Not Covered
75% of Reasonable and Customary allowance

### Occupational, and Speech Therapy
Limited to a maximum benefit of $20 per day.
$35 Copayment and 80% of Preferred Allowance
80% of Preferred Allowance
75% 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
75% of Reasonable and Customary allowance

### Hospice Facility or Home Hospice
Up to a combined maximum benefit of 180 days. Includes up to six visits for Bereavement Counseling.
$0 copayment and 80% of Preferred Allowance
80% of Preferred Allowance
75% of Reasonable and Customary allowance

### Special Provisions
80% of Preferred Allowance (copayments may apply to certain visit/procedures)
80% of Preferred Allowance
75% of Reasonable and Customary allowance
Refer to Section XI, Special Provisions.

---

*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, Schedule of Prescription Benefits.
## Schedule of Medical Benefits

### Section VI

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coinsurance Amount (What the SHBP Pays)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Princeton Area</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physicians: Private Health Care Systems/Multiplan (<a href="http://www.PHCS.org">www.PHCS.org</a>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital: University Medical Center at Princeton</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trinity Counseling Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outside Princeton Area</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Health Care Systems (<a href="http://www.PHCS.org">www.PHCS.org</a>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

### 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 $25 for outpatient Mental/Nervous Disorder counseling.

### Spiritual Direction

- Copayments 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.
- Copayments for Spiritual Direction, Psychotherapy, and Support Groups are $5 per session groups with outside facilitators.

**Not Covered**

**Not Covered**

Group benefits are administered internally by Princeton Theological Seminary.

In-Network Providers in the Princeton Area include Trinity Counseling Service and the Specialty Counseling Network.

Trinity Counseling Service benefits begin after the Seminary has provided 10 lifetime visits under the Student Administrative Health Fee.

This benefit includes coverage for pre-marital counseling.
<p>| Support and Psychotherapy Groups Provided by Counseling at Princeton Theological Seminary | $15 Copayment Per Group Session | Not Covered | Not Covered | Referral is required from PTS Counseling. |</p>
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Copayments (What You Pay)</th>
<th>Pharmacies that do not participate with HealthSmart Rx</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Plan Year Deductible</strong></td>
<td>A one-time Annual Plan Year Deductible of $50.00 must be satisfied before prescription drug benefits will be paid under the In-Network out-of-network prescription drug coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$15 Copayment</td>
<td></td>
<td>Same Copayment schedule for In-Network Pharmacies - the maximum allowance is the lesser of the HealthSmart Rx Maximum Allowable Cost under the HealthSmart Rx fee schedule or the Reasonable and Customary Charge allowance.</td>
</tr>
<tr>
<td><strong>Preferred Brand Name</strong></td>
<td>$25 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Name</strong></td>
<td>$40 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td>Generic: $30 Copayment</td>
<td></td>
<td>Refer to Section X, Prescription Drugs, for instructions for using the Mail Order program with HealthSmart Rx.</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Name: $50 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Name: $80 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The maximum per prescription is a 90-day supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copayment Per Prescription - 30 Day Supply</td>
<td></td>
<td>Special arrangements can be made for extended supplies for students traveling abroad (contact the Claims Administrator).</td>
</tr>
</tbody>
</table>
Preventive Care

Preventive Care Benefits are provided by the SHBP in full compliance with the Patient Protection and Affordable Care Act (PPACA). PPACA Required Care Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services and services received at In-Network Providers.

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

PPACA Required Care Benefits are subject to change, pursuant to determinations by the U.S. Department of Health and Human Services and the U.S. Preventive Services Task Force. Refer to the SHBP website for updates.

Covered Preventive Services for Adults (age 19 or over)

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over age 50.
- Depression screening for adults.
- Type 2 diabetes screening for adults with high blood pressure.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adults at higher risk.
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
  - hepatitis a
  - hepatitis b
  - herpes zoster
  - human papillomavirus
  - influenza (flu shot)
  - measles, mumps, rubella
  - meningococcal
  - pneumococcal
  - tetanus, diphtheria, pertussis
  - varicella
- Obesity screening and counseling for all adults.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Tobacco Use screening for all adults and cessation interventions for tobacco users.
- Syphilis screening for all adults at higher risk.
Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women.
- BRCA counseling about genetic testing for women at higher risk.
- Breast cancer mammography screenings every 1 to 2 years for women over 40 years.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Well-woman visits to obtain recommended preventive services for women under age 65.

Covered Preventive Services for Children

- Alcohol and Drug Claims Administrator assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children of all ages (up to age 18).
- Blood Pressure screening for children (up to age 18).
- Cervical Dysplasia screening for sexually active females.
- Congenital Hypothyroidism screening for newborns.
- Depression screening for adolescents.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Dyslipidemia screening for children at higher risk of lipid disorders (up to age 18).
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years).
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary) including:
  - diphtheria, tetanus, pertussis
  - haemophilus influenzæ type b
  - hepatitis a
  - hepatitis b
  - human papillomavirus
  - inactivated poliovirus
  - influenza (flu shot)
  - measles, mumps, rubella
  - meningococcal
  - pneumococcal
  - rotavirus
  - varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Obesity screening and counseling.
- Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years).
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years).
- Vision screening for all children.

**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

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Oral Exams</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% (no Deductibles, Copayments, or Coinsurance)</td>
<td>• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures).</td>
</tr>
<tr>
<td></td>
<td>• Periodic or routine oral exams; twice in 12 months.</td>
</tr>
<tr>
<td></td>
<td>• Oral exams for a member under age three; twice in 12 months.</td>
</tr>
<tr>
<td></td>
<td>• Limited oral exams; twice in 12 months.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>X-rays</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% Coinsurance.</td>
<td>• Single tooth x-rays; no more than one per visit.</td>
</tr>
<tr>
<td></td>
<td>• Bitewing x-rays; twice in 12 months.</td>
</tr>
<tr>
<td></td>
<td>• Full mouth x-rays; once in 36 months per provider or location.</td>
</tr>
<tr>
<td></td>
<td>• Panoramic x-rays; once in 36 months per provider or location.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Routine Dental Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% Coinsurance.</td>
<td>• Routine cleaning, minor scaling, and polishing of the teeth; twice in 12 months.</td>
</tr>
<tr>
<td></td>
<td>• Fluoride treatments; once per calendar quarter.</td>
</tr>
<tr>
<td></td>
<td>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered).</td>
</tr>
<tr>
<td></td>
<td>• Space maintainers.</td>
</tr>
</tbody>
</table>

## Group 2— Basic Restorative Services

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Fillings</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% Coinsurance.</td>
<td>• A amalgam (silver) fillings; one filling per tooth surface in 12 months.</td>
</tr>
<tr>
<td></td>
<td>• Composite resin (white) fillings; one filling per tooth surface in 12 months (for primary, back teeth, payment for a composite filling will not be more than the amount allowed for an amalgam filling).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Root Canal Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% Coinsurance.</td>
<td>• Root canals on permanent teeth; once per tooth.</td>
</tr>
<tr>
<td></td>
<td>• Vital pulpotomy.</td>
</tr>
<tr>
<td></td>
<td>• Retreatment of prior root canal on permanent teeth; once per tooth in 24 months.</td>
</tr>
<tr>
<td></td>
<td>• Root end surgery on permanent teeth; once per tooth.</td>
</tr>
<tr>
<td>PPACA REQUIRED BENEFITS</td>
<td>Section VIII</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crowns (see also Group 3)</th>
<th>• Prefabricated stainless steel crowns; once per tooth (primary and permanent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gum treatment</td>
<td>• Periodontal scaling and root planing; once per quadrant in 36 months</td>
</tr>
<tr>
<td></td>
<td>• Periodontal surgery; once per quadrant in 36 months</td>
</tr>
<tr>
<td>Prosthetic maintenance</td>
<td>• Repair of partial or complete dentures and bridges; once in 12 months</td>
</tr>
<tr>
<td></td>
<td>• Reline or rebase partial or complete dentures; once in 24 months</td>
</tr>
<tr>
<td></td>
<td>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>• Simple tooth extractions; once per tooth</td>
</tr>
<tr>
<td></td>
<td>• Erupted or exposed root removal; once per tooth</td>
</tr>
<tr>
<td></td>
<td>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</td>
</tr>
<tr>
<td></td>
<td>• Other necessary oral surgery</td>
</tr>
</tbody>
</table>

**Group 3—Major Restorative Services**

<table>
<thead>
<tr>
<th>Crowns</th>
<th>Resin crowns; once per tooth in 60 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Porcelain/ceramic crowns; once per tooth in 60 months</td>
</tr>
<tr>
<td></td>
<td>Porcelain fused to metal/high noble crowns; once per tooth in 60 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tooth replacement</th>
<th>Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other necessary services</th>
<th>Occlusal guards when necessary; once in calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fabrication of an athletic mouth guard</td>
</tr>
</tbody>
</table>

**Orthodontic Services**

<table>
<thead>
<tr>
<th>Medically necessary orthodontic care that has been preauthorized for a qualified member</th>
<th>Braces for a member who has a severe and handicapping malocclusion Related orthodontic services for a member who qualifies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule of Benefits</td>
<td></td>
</tr>
<tr>
<td>50% Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
**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 one (1) benefit per Plan Year.
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 for their services to the SHBP at negotiated rates 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 SHBP-Covered Persons through the PHCS/Multiplan Network at www.PHCS.com or www.Multiplan.com. Refer also to the availability of In-Network pharmacy provider for HealthSmart Rx.

The University of Medical Center at Princeton, Trinity Counseling Services, and counselors, psychiatrists, and other licensed mental Health Care Providers have contracted directly with the Plan Sponsor to be In-Network Providers 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-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 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 SHBP-Covered Person. The family deductible applies collectively to all SHBP-Covered Persons 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 Copayments 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 an SHBP-Covered Person must pay during a Plan Year. The individual out-of-pocket maximum applies separately to each SHBP-Covered Person. When an SHBP-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 SHBP-Covered Persons 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 Charges.
• Charges in excess of Benefit Maximums.

**Benefit Maximums**
Total plan payments for each SHBP-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
SHBP-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 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.
- Dental services received after an accidental Injury to teeth, excluding biting or chewing Injuries. This includes replacement of teeth and any related X-rays.
- 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 an 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.
- Infertility treatment, only for artificial insemination and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs are covered.

**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 Charges 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.

• 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

• Mental Illness or Substance Abuse Care
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).

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 SHBP-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. Blood factors are limited to three treatments per Plan Year.

• 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.

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.
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, PPACA Required Care 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.

- Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet, except as specifically provided for treatment of diabetes.

- 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 Special Provisions.

- 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 SHBP-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.

• Services or supplies furnished, paid for or for which benefits are provided or required by reason of past or present service of any SHBP-Covered Person in the armed forces of a government.

• Travel expenses of a Physician.

• Travel expenses of an SHBP-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.

• Sex change Surgery.

• Penile prosthetic implants.

• Reproductive sterilization or reversal of any reproductive sterilization procedure.

• Services related to Dental or Oral surgery (including diagnosis or treatment of temporomandibular joint dysfunction or related conditions), except as specifically provided for Children under age 19 as specified in Section VII, PPACA Required Care Benefits.

• 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 for Children under age 19 as specified in Section VII, PPACA Required Care 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 keratomeleusis Surgery.

- Hearing examinations, hearing aids or related supplies.
- Adoption expenses.
- Surrogate expenses.
- Biofeedback.
- Hypnosis.
- Genetic counseling or genetic testing.
- Routine PAP tests, routine physical exams, vaccinations, inoculations or immunizations, except as specifically provided in the Section VIII, PPACA Required Care Benefits.
- 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, PPACA Required Care Benefits.
- Weight reduction Surgery, treatment, procedures, services or supplies, regardless of a condition of morbid obesity.
- Services for treatment of non-Biologically Based Mental Illness disorders, mental retardation, or 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.
**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 HealthSmart Rx as the prescription benefit program manager. When you fill a covered prescription at a HealthSmart Rx participating pharmacy and show your SHBP Identification Card with the HealthSmart 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 HealthSmart Rx Network, you must pay for the full cost of the purchase and then submit a claim for benefits to HealthSmart Rx to be reimbursed. A pharmacy that does not participate with HealthSmart 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.
- Emergency allergic kits.
- Imitrex (all dosage forms).
- Glucagon emergency kits.
- Synagis and Respigam.
- Allergy serums (all dosage forms).

**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).

- Fertility and 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, Special Provisions 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.

- Anti-obesity medications.

- 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.

- Injectable medications, except as listed under Covered Drugs.

- 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 HealthSmart 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 HealthSmart Rx By Mail Order Form and mail it directly to HealthSmart 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.Expressscripts.com](http://www.Expressscripts.com).
Except for services or supplies covered at 100 percent under Section VIII, PPACA 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 Special Provisions, unless otherwise specified.

**Integration with PPACA Required Care Benefits**

In instances where eligibility for benefits are greater in this Special Provisions than provided under PPACA Required are Benefits, this Section will prevail in determining SHBP benefits. Conversely, if eligibility or coverage is greater under Care Benefits than specified in this Section for Special Provisions, the PPACA Required Care Benefits will prevail in determining SHBP benefits.

**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. This benefit includes 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. This benefit also includes the cost of a prosthesis.

**Diabetes**

Benefits will be paid the same as any other Sickness for the following equipment and supplies for treatment of diabetes if recommended or prescribed by a Physician or other Health Care Provider: 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 provided for self-management education and education relating to diet are limited to Medically Necessary visits upon the diagnosis of diabetes upon the diagnosis by a Physician or other Health Care Provider of a significant change in the SHBP-covered person’s symptoms or conditions which necessitates changes in that person’s self-management or upon determination by a Physician or other Health Care Provider that reeducation or refresher education is necessary.

**Colorectal Cancer Screening**

Benefits will be provided at 100 percent, not subject to copayments, deductible, or coinsurance, for colorectal cancer screening at regular intervals for SHBP-Covered Persons age 50 and over and for SHBP-Covered Persons of any age who are considered to be at high risk for colorectal cancer. Refer also to PPACA Required Care.

High risk for colorectal cancer means a person has:

- a. family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
- b. chronic inflammatory bowel disease; or
- c. a background, ethnicity or lifestyle that a Physician believes puts the person at elevated risk for colorectal cancer.

The methods of screening for which benefits shall be provided shall include:

- a. a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or
- b. the most reliable, medically recognized screening test available.
SPECIAL PROVISIONS  

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 to be Medically Necessary.

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.

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 SHBP-Covered Person by a licensed audiologist or speech language pathologist.

Maternity Testing
Benefits will be paid the same as any other Sickness for routine maternity tests and screening exams.

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

For all SHBP-Covered Persons 19 years of age or older:

a. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, amid blood cholesterol level; or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level: and

b. 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.

For all SHBP-Covered Persons 35 years of age or older: a glaucoma eye test every five years.

For all SHBP-Covered Persons 40 years of age or older: an annual stool examination for presence of blood.

For all SHBP-Covered Persons 45 years of age or older: a left-sided colon examination of 35 to 60 centimeters every five years.

Inherited Metabolic Disease
Benefits will be provided at 100 percent, not subject to copayments, deductible, or coinsurance, 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.

**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.

**Non-Standard Infant Formula**
Benefits will be paid on the same basis as other Prescription Drugs for the purchase of specialized non-standard infant formulas, when the SHBP-covered infant’s Physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be Medically Necessary.
**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 SHBP-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:
The responsible party, their insurer, or any other source on behalf of that party;

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

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

any worker’s compensation or other liability insurance company; or

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:

(1) the Plan Administrator;
(2) the SHBP Management Committee;
(4) Professional staff and/or clinicians or counselors of the Plan Sponsor’s Counseling Center; and
(5) 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 (HIPAA), 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 in any and all respects at any time, and from time to time, without prior notice. Any such amendment will be by a written instrument 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 as soon as is administratively feasible after its adoption.

**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 (QM CSO) 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), 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.

For the 2014-2015 Plan Year, the Seminary is voluntarily complying 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).
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:
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 Providers.

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 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 entitled External Review.

**Second Level Internal Grievance**

It is your option, if you are the Seminaryappy with the 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 voluntary compliance with the Patient Protection and Affordable Care Act (PPACA), a request to the Commissioner of Insurance for the State of New Hampshire 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 the 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 an 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:

1. causes Injury to the physical structure of the body;
2. results from an external agent of trauma;
3. 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 are 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 website: www.ptsem/current/healthresources/.

**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 SHBP-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 SHBP-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 SHBP-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 SHBP-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 Charges. The SHBP-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 an Sickness or Injury.
DEFINITIONS

Covered Expense(s)/Service(s): A health service or supply that is eligible for benefits when performed by a Provider or Physician. A Covered Expense(s)/Service(s) 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.

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 an 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

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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.

**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.
DEFINITIONS

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 SHBP-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., Psy. D., M.A), 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 SHBP-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 care for an SHBP-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 an 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 an 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 collectively as In-Network Providers. 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.

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

**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 care 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 Sponsored by Princeton Theological Seminary for Princeton Theological Seminary students and/or their eligible dependents.


**HealthSmart Rx Network Maximum Allowable Cost.** The maximum amount that a pharmacy in the HealthSmart 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 Hospitalization.** 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 Nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activi-
ties 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 SHBP-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 Allowance.** 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.
DEFINITIONS Section XVII

(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 multi-disciplinary 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.

**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.

**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 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 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.