SUMMARY PLAN DESCRIPTION
FOR

LUMBERTON BOARD OF EDUCATION
SCHOOL'S HEALTH INSURANCE FUND

AETNA CHOICE POS II $10

AETNA CHOICE POS II $10 MEDICAL SCHEDULE OF BENEFITS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. Not all participants may be eligible for all Schedule of Benefits described in this section. Enrollment in specific Schedule of Benefits or plans may be subject to union contracts, date of hire, or participant contributions.

Verification of Eligibility See Back of ID card

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: Your plan may require that certain services must be precertified or reimbursement from the Plan may be reduced. Refer to your Plan's Medical Benefits Schedule regarding precertification and see the Cost Management section for more details on authorization requirements for services.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

The Plan is a plan which offers a Network Provider Organization.

PPO name: Aetna Health Inc.
Address: P.O. Box 981107
El Paso, TX 09998

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

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Non-Network Providers:
The higher In-Network payment will be made for certain Non-Network services if a Covered Person is out of the Network service area and has a Medical Emergency requiring immediate care. If your health plan includes benefits for non-network services or supplies, and you choose to receive services or supplies from a non-network provider (doctor, other health care professional or facility) you generally will have to pay more out of pocket than if you used in-network doctors, health care professionals and/or facilities. Non-network providers are not contractually obligated to accept the plan’s payment as payment in full and the provider may bill you for any balance of the billed charges.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior

authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider.

The higher In Network payment will be made for certain Non Network services if a Covered Person is out of the Network service area and has a Medical Emergency requiring immediate care.

Deductibles and certain Copayments and/or Coinsurance are payable by Plan Participants.

Deductibles and certain Copayments and/or Coinsurance are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. Each January 1st, a new deductible amount is required. For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For family coverage, the deductible must be met as a Family Unit, without regard to which family member incurred the expenses.

A copayment and/or coinsurance is the amount of money that is paid each time a particular service is used. Typically, there may be copayments or coinsurance on some services and other services will not have any copayments or coinsurance.

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% of allowable amount (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out of pocket limit, Covered Charges for that Family Unit will be payable at 100% of allowable amount (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the medical, Rx, and dental plans including the ones described in this document. The Maximum Benefit Amount for Essential Health Benefits will not apply in Plan Years beginning on or after January 1, 2014.

SUMMARY OF MEDICAL BENEFITS

Aetna Choice POS II $10 PCP Selection Not Required	NETWORK PROVIDERS Based on Contracted Fees	NON-NETWORK PROVIDERS Based on the Allowed Amount
DEDUCTIBLE PER CALENDAR YEAR		
Per Covered Person	N/A	$100
Per Family Unit	N/A	$250
No deductible carryover applies from previous benefit period.		
PRECERTIFICATION REQUIREMENT		
Plan requires precertification of Medical Necessity for certain services before Medical and/or Surgical services are provided. Please see the Cost Management section of this booklet for more details. Failure to follow precertification procedures may reduce benefit payment by the plan. Contact your claims adminstrator for any applicable penalty amounts.		
SECOND AND/OR THIRD OPINION PROGRAM REQUIREMENT		
Second and/or third opinion program is encouraged but not required by this Plan. Please see the Cost Management section of this booklet for more details.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$400	$2,000
Per Family Unit	$800	$5,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the Maximum Out-of-pocket Amount and are never paid at 100%: - Cost containment penalties, Charges over the Allowed Amount, Non-covered charges All In-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the In-Network Maximum Out-of-pocket amount. All Non-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the Non-Network Maximum Out-of-pocket amount.		
COVERED CHARGES		
Hospital Services		
Inpatient	100% covered	Subject to deductible; 80% coinsurance
Intensive Care Unit	100% covered	Subject to deductible; 80% coinsurance
Emergency Room Visit - Payment at the In-Network level applies only to true Medical emergencies and Accidental Injuries.		
Medical Emergency	$25 copayment	$25 copayment
Urgent Care	$10 copayment	Subject to deductible; 80% coinsurance
Skilled Nursing Facility	100% covered	Subject to deductible; 80% coinsurance
Benefit Maximum	120 day/calendar year in-network; 60 days/calendar year out-of-network	
Physician Services		
Inpatient visits	100% covered	Subject to deductible; 80% coinsurance
Office visits	$10 copayment	Subject to deductible; 80% coinsurance
Specialist visits	$10 copayment	Subject to deductible; 80% coinsurance
Maternity OB Visits	$10 copayment applies to first office visit; then 100% covered	Subject to deductible; 80% coinsurance
Surgery	100% covered	Subject to deductible; 80% coinsurance
Allergy Testing	Based on Place of Service	Subject to deductible; 80% coinsurance
Allergy Treatment	Based on Place of Service	Subject to deductible; 80% coinsurance
Diagnostic Testing (X-ray & Lab)	100% covered	Subject to deductible; 80% coinsurance
Home Health Care	100% covered	Subject to deductible; 80% coinsurance
Inpatient Prescription Drugs	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Retail - Prescription Drugs	Not Covered	Not Covered

Aetna Choice POS II $10 PCP Selection Not Required	NETWORK PROVIDERS Based on Contracted Fees	NON-NETWORK PROVIDERS Based on the Allowed Amount
Outpatient Private Duty Nursing	100% covered	Subject to deductible; 80% coinsurance
Hospice Care Contact your claims administrator for any limitations that may apply	100% covered	Subject to deductible; 80% coinsurance
Ambulance	Emergency Transport - Covered 90%; Non-Emergent Transport - Not Covered, except 80% coinsurance after deductible if pre-authorized	Emergency Transport - Covered 90%; Non-Emergent Transport - Not Covered, except 80% coinsurance after deductible if pre-authorized
Jaw Joint/TMJ	Based on Type and Place of Service	Based on Type and Place of Service
Wig After Chemotherapy	100% covered	100% covered
Benefit Limit	$500 benefit maximum per 24-month period	
Occupational Therapy*	$10 copayment	Subject to deductible; 80% coinsurance
Speech Therapy*	$10 copayment	Subject to deductible; 80% coinsurance - limited to 60 visits/calendar year, in and out-of-network combined
Physical Therapy*	$10 copayment	Subject to deductible; 80% coinsurance
Benefit Limit	Based on medical review	
Refer to "Autism or Another Developmental Disability"in the Covered Charges section for information specific to therapy coverage associated with a diagnosis of Autism.		
Durable Medical Equipment	90% coinsurance	Subject to deductible; 80% coinsurance
Vision Eyewear	Not Covered	Not Covered
Hearing Aid Devices	90% coinsurance	Subject to deductible; 80% coinsurance
Benefit Limit	Coverage for persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.	
Prosthetics	90% coinsurance	Subject to deductible; 80% coinsurance; requires precertification over $1500
Orthotics	90% coinsurance	Subject to deductible; 80% coinsurance
Spinal Manipulation Chiropractic	$10 copayment	Subject to deductible; 80% coinsurance
Benefit Limit	Maximum of 30 visits per calendar year	
Mental Disorders		
Inpatient	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Outpatient	$10 copayment	Subject to deductible; 80% coinsurance
Substance Abuse		
Inpatient	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Outpatient	$10 copayment	Subject to deductible; 80% coinsurance
Preventive Care		
Routine Well Adult Care	100% covered	80% coinsurance
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or tobacco use, colonoscopies and services for pap smear, mammogram, prostate screening, gynecological exam, screening for blood pressure, cholesterol, type 2 diabetes, HIV, immunizations/flu shots. Refer to healthcare.gov for complete listing.		
Routine Gynecological Exam	100% covered	80% coinsurance
Routine Mammograms	100% covered	80% coinsurance
Routine Well Newborn & Child Care	100% covered	80% coinsurance
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or drug use, screening for autism, blood pressure, congenital hypothyroidism, developmental, hearing, lead, and vision, immunizations/flu shots, behavioral assessment. Refer to healthcare.gov for complete listing.		

Aetna Choice POS II $10 PCP Selection Not Required	**NETWORK PROVIDERS Based on Contracted Fees**	**NON-NETWORK PROVIDERS Based on the Allowed Amount**
Eye Exam Frequency limits may apply	Specialist copay applies - limited to one routine exam/calendar year	Not Covered
Organ Transplants	Refer to Associated Medical Service - Contact your Claims Administrator	Refer to Associated Medical Service - Contact your Claims Administrator
Infertility Benefits	Refer to Associated Medical Service	Refer to Associated Medical Service
Benefit Limitations	*Coverage subject to current New Jersey State Mandate. Treatment covered with limitations. Contact your Claims Adminstrator for more details*	

AETNA CHOICE POS II $10 COVERED CHARGES

Covered Charges are the Allowed Amount that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Hospital Care. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Coverage of Pregnancy. The Allowed Amount for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

a) the patient is confined as a bed patient in the facility; and

b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

Physician Care. The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowed Amount that is allowed for the primary procedures; a percentage of the Allowed Amount will be allowed for each additional procedure performed through the same incision. Contact your claims administrator for specifications and details. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowed Amount for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the percentage of the Allowed Amount for that procedure; and

c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowed Amount.

Private Duty Nursing Care. The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

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

b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Charges for Private Duty Nursing Care are subject to the limits as described in the Schedule of Benefits.

Home Health Care Services and Supplies. Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Hospice Care Services and Supplies. Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Acupuncture coverage is provided in lieu of anesthesia for a surgical procedure covered under the plan or for pain management when preauthorized as medically necessary, and the provider administering it is a legally qualified physician practicing within the scope of his/her license.

Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

Autism or Another Development Disability:

- Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
- Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability. Visitation limits for therapies do not apply for individuals diagnosed with autism;
- Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals diagnosed with autism;

- A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

ABA therapy is not eligible for individuals with developmental diagnoses.

Precertification is necessary for ABA and all other therapy services.

Cost sharing for these services are payable on the same basis as for other conditions. Therapy Services available under this provision are payable separately from therapies for other conditions and will not reduce the Therapy Services benefits available under the Plan for those other conditions.

The provider shall submit a treatment plan in writing which includes:
1) Diagnosis;
2) Proposed Services including frequency and duration;
3) Goals

The Plan may request additional information as needed to determine coverage under this Program and updated treatment plans as needed.

Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

Initial **contact lenses** or glasses required following cataract surgery.

Diabetes Benefit - This Program covers dialysis services that are furnished by a dialysis center. This Program also provides benefits for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist;

a. blood glucose monitors and blood glucose monitors for the legally blind;
b. test strips for glucose monitors and visual reading and urine testing strips;
c. insulin;
d. injection aids;
e. cartridges for the legally blind;
f. syringes;
g. insulin pumps and appurtenances to them;
h. insulin infusion devices; and
i. oral agents for controlling blood sugar.

Subject to the terms below, this Program also covers diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the Illness. This includes information on proper diet.

a. Benefits for self-management education and education relating to diet shall be limited to Visits that are Medically Necessary and Appropriate upon:

    1. the diagnosis of diabetes;
    2. the diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the Covered Person's symptoms or conditions which requires changes in the Covered Person's self-management; and

3. determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is needed.

b. Diabetes self-management education is covered when rendered by:

1. a dietician registered by a nationally recognized professional association of dieticians;
2. a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
3. a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.

Donated Breast Milk. Expenses incurred for the provision of pasteurized donated human breast milk, which shall include human milk fortifiers if indicated in a medical order provided by a licensed medical practitioner, to an infant under the age of six months, provided that the milk is obtained from a human milk bank that meets quality guidelines established by the Department of Health and a licensed medical practitioner has issued a medical order for the infant under at least one of the following circumstances:

1. the infant is medically or physically unable to receive maternal breast milk or participate in breast feeding or the infant's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support or
2. the infant meets any of the following conditions:
   a. a body weight below healthy levels determined by the licensed medical practitioner
   b. a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis; or
   c. a congenital or acquired condition that may benefit from the use of donor breast milk and human milk fortifiers as determined by the Department of Health.

Care, supplies and services for the diagnosis and treatment of **Infertility**. Subject to the limits as described in your Summary of Benefits.

Infusion Therapy. The administration of antibiotic, nutrient or other therapeutic agents by direct infusion.

Laboratory studies. Covered Charges for diagnostic and preventive lab testing and services.

Treatment of **Mental Disorders and Substance Abuse**. Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

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

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth where repair occurs within 12 months after the accident. But, this is only if the Injury was not caused, directly or indirectly, by biting or chewing.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Organ transplant limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances, including foot orthotic, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The Plan does not cover: fabric and elastic supports; corsets; trusses; elastic hose; canes; crutches; cervical collars; or dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Prescription Drugs (as defined).

Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered except for Autism and Pervasive Development Disorder (PDD).

Speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C.

Sterilization procedures.

Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

Medically Necessary surgical services for care and treatment of jaw joint conditions, including **Temporomandibular Joint syndrome (TMJ).** The Plan excludes charges for orthodontia, crowns or bridgework, and appliances.

Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowed Amount for nursery care for the first 48 hours after a vaginal delivery or 96 hours after a cesarean section days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

An Employee must enroll a newborn for coverage by filling out and signing an enrollment application. A newborn child will be automatically enrolled for 60 days from birth; thereafter, a separate enrollment for a newborn child is required. A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 60 days. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled within 60 days of birth, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for Routine Physician Care. The benefit is limited to the Allowed Amount made by a Physician for routine pediatric care for the first 48 hours after vaginal delivery or 96 hours after a cesarean section days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

Charges associated with the initial purchase of a **wig** are subject to the limits as described in the Schedule of Benefits.

Diagnostic **x-rays**.

Aetna Choice POS II $10 COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services if required by the Plan. This call must be made at least 7 business days in advance of services being rendered or within 48 hours after a Medical Emergency.

Refer to your Plan's Summary of Medical Benefits Schedule for precertification requirements. If precertification is required, failure to follow the procedure will reduce reimbursement received from the Plan as stated in your Plan's Summary of Medical Benefits Schedule.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the deductible, out-of-pocket payment or copayments. Your provider is responsible for obtaining authorization for in-network covered services. When you self-refer, you are responsible for obtaining the necessary precertification.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) As referenced in your Plan's Summary of Medical Benefits Schedule, Precertification of Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided. This list does not represent coverage for Excluded Benefits by your Plan. **As patterns of medical practice change, the specific procedures which should be precertified may also change. Please contact the Claims Administrator for updated services.**

Cardiac rehabilitation therapy
Transplants or Implants
Durable Medical Equipment
Home Health Care
Hospice Care
Hospitalizations
Infertility Services
Inpatient Substance Abuse/Mental Disorder treatments
Magnetic Resonance Imaging or Angiography (MRI or MRA)
Nuclear Medicine Imaging (including cardiac procedures)
Outpatient surgical procedures or testing
Pacemakers
Pain Management Services
Positron Emission Tomography (PET) Scans
Private Duty Nursing
Reconstructive Surgery
Skilled Nursing Facility stays

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 business days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan. See your Plan's Summary of Medical Benefits Schedule for requirements.**

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

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

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

Refer to your Plan's Summary of Medical Benefits Schedule for second and/or third opinion program requirements. If required, failure to follow the procedure will reduce reimbursement received from the Plan as stated in your Plan's Summary of Medical Benefits Schedule.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the deductible, out-of-pocket payment or copayments. Your provider is responsible for obtaining authorization for in-network covered services. When you self-refer, you are responsible for obtaining the necessary precertification.

Second and/or third opinions are strongly recommended even if not required according to your Plan’s Summary of Medical Benefits. As patterns of medical practice change, the specific procedures which should have a second opinion also change. All Covered Persons can receive a list of surgeries for which a second and/or third opinion is strongly recommended. Please contact the Plan Administrator or the utilization review administrator for this list.

Before a Covered Person has a surgery performed that is on the list, the Covered Person should contact the utilization review administrator at:

as listed on the Employee's ID card

to receive information on how to obtain a second and/or third opinion to confirm the need for the surgery.

These additional consultations must be performed by Physicians who are:

(a) Board Certified Specialists in the area in which the operation is concerned; and

(b) not financially associated with either the surgeon originally recommending surgery or, in the case of a third opinion, with each other.

If the second opinion does not confirm the need for surgery, a third opinion should be obtained before the surgery is scheduled. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if the Covered Person desires the procedure.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

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

Aetna Choice POS II $10 DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowed Amount is the maximum amount a plan will pay for a covered health care service. For Network Providers, the allowed amount is contractually agreed upon. For Non-Network Providers, the claims administrator may use different sources to calculate the reimbursement for services including industry resources provided by entities such as *FAIR Health,* the *Centers for Medicare & Medicare Services (CMS)* and other databases. The plan administrator uses these fee schedules to calculate a reimbursement allowance that corresponds to your plan's non-network benefits, taking into account your coinsurance, copayment, non-network deductible or any other member out of pocket costs that apply to the claim.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Civil Union: A union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a Civil Union.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employer is Lumberton Board of Education.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Infusion Therapy is the administration of antibiotic, nutrient or other therapeutic agents by direct infusion.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 60-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department

of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Lumberton Board of Education, School's Health Insurance Fund, which is a benefits plan for certain Employees of Lumberton Board of Education and is described in this document.

Plan Participant is any Employee, or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Primary Care Physician (PCP)- The Affordable Care Act preserves your choice of an available primary care provider from within your health plan's provider network. This includes a pediatrician in the case of a child, and women have the right to access an OB/GYN without getting an authorization or referral.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Aetna Choice POS II $10 EXCLUSIONS

Charges for the following are not covered for Medical Benefits shown in the Medical Schedule of Benefits. Please see the Prescription Drug, Dental Plan and Vision Plan, if applicable, for exclusions related to the Prescription Drug Plan, Dental Plan and Vision Plan.

Administration of **Oxygen** unless otherwise stated in this Plan**.**

Ambulance in the case of a non-Medical Emergency.

Anesthesia and consultation services when associated with a non-covered charge.

Biofeedback services, except as specifically approved by your plan. Contact your claims administrator for details.

Blood or **blood plasma** or other blood derivatives or components that are replaced by either the Covered Person or Representative.

Broken Appointments.

Completion of Claim Forms or requests for Medical Records.

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

Consumable medical supplies.

Procedures, treatments, drugs, and biological products associated with **Cosmetic Services**. Complications of cosmetic surgery.

Court ordered treatment that is not Medically Necessary and Appropriate as defined by the Plan.

Criminal activity. Costs for services resulting from the commission, or attempt to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation.

Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

Dental Services, treatments and procedures unless specifically listed as a covered benefit in this Plan. This includes, but is not limited to restoration of tooth structure, endodontic treatment of teeth, surgery and related services for treatment of periodontal disease, osseous surgery, other surgery to the periodontium, replacement of missing teeth, removal and re-implantation of teeth and any related services, any orthodontic treatment, dental implants and related services and orthognathic surgery.

Therapies or activities that are **Diversional** or recreational.

Educational or vocational testing and counseling. Services for educational or vocational testing, training or counseling..

Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowed Amount.

Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

Food products including enterally administered food products. This exclusion does not apply to foods, food products and specialized non-standard infant formulas that are eligible under Inherited Metabolic Disease.

Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as described in the schedule of benefits.

Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting, except as listed in the Summary of Medical Benefits and covered under the well adult or well child sections of this Plan.

Home Health Care Visits for the care of non-biologically based mental illness.

Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Immunizations unless otherwise stated in this Booklet.

Light box therapy and the appliance that radiates the light.

Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

Methadone maintenance.

Milieu Therapy even though other cover treatment may also be provided.

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

Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

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

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, unless there is a diagnosis of morbid obesity.

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

Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

Charges for benefits after **Plan maximums** have been reached.

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

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

Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law. This includes but not limited to services connected to: pre-marital or similar exams or tests, research studies, education or experimentation, mandatory consultations required by facility regulations, exams, screenings and/or tests for school, activities, pre-employment or employment.

Self-Inflicted. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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

Skin outgrowths and other growths removal that are abnormal. This includes, but is not limited to, paring or chemical treatments to remove: callouses, corns, hornified nails and warts and all other growths, unless it involves cutting through all layers of skin. This does not apply to services needed for the treatment of diabetes.

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

Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

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

Therapies considered as **maintenance**.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

Vision therapy; vision or visual acuity training; orthoptics; pleoptics.

War. Any loss that is due to a declared or undeclared act of war.

Weight Loss clinics, health clubs and similar programs.

VISION BENEFITS

Aetna Vision Plan - Full Gold Plan		
	In Network	**Out of Network**
Exam		
Use your Exam coverage once every calendar year.		
Routine/Comprehensive Eye Exam	$10 Copay	$40 Reimbursement
Standard Contact lens Fit/Follow up	Member pays discounted fee of $40	Not Covered
Premium Contact Lens Fit/Follow-Up	Member pays 90% of retail	Not Covered
Eyeglass Lenses / Lens options		
Use Lens coverage to purchase either/both eyeglass lenses or contacts up to $200 annual allowance.		
Single Vision lenses	$0 Copay	$35 Reimbursement
Bifocal Vision lenses	$0 Copay	$55 Reimbursement
Trifocal Vision lenses	$0 Copay	$100 Reimbursement
Lenticular Vision lenses	$0 Copay	$100 Reimbursement
Standard Progessive Vision lenses	$65 Copay	$55 Reimbursement
Premium Progressive Vision lenses[1]	20% Discount off retail minus $120 plan allowance plus $65 Copay = member out-of-pocket	$55 Reimbursement
UV Treatment	Member pays discounted fee of $15	Not Covered
Tint (Solid and Gradient)	Member pays discounted fee of $15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of $15	Not Covered
Standard Polycarbonate lenses - Adult	Member pays discounted fee of $40	Not Covered
Standard Polycarbonate Lenses - Children to age 19	Member pays discounted fee of $40	Not Covered
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Photochromic/Transitions plastic	Member pays 80% of Retail	Not Covered
Polarized	Member pays 80% of Retail	Not Covered
Contact Lenses		
Use Lens coverage to purchase either/both eyeglass lenses or contacts up to $200 annual allowance.		
Conventional contact lenses	$200 Allowance** Add'l 15% off balance over allowance	$105 Reimbursement
Disposable contact lenses	$200 Allowance	$105 Reimbursement
Medically necessary contact lenses	$0 Copay	$250 Reimbursement
Frames		
Use your Frame coverage once every 2 calendar years.		
Any Frame available, including frames for prescription sunglasses	$130 Allowance Add'l 20% off balance over Allowance.	$100 Reimbursement
Discounts		
Discounts cannot be combined with other discounts or promotional offers and may not be available on all brands.		
Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances** have been exhausted.	Up to a 40% Discount	No Discount
Non-covered items such as cleaning cloths and contact lens solution[2]	20% Discount	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] only. Call 1-800-422-6600	15% discount off retail or 5% discount off the promotional price	No Discount
Retinal Imaging[4]	Member pays a discounted fee up to $39	No Discount
Replacement contact lenses	Receive savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit www.aetnavision.com for details.	No Discount

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to

receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

**Frame allowance is a one-time use benefit. Contact lens allowance is a declining balance benefit and can be used throughout the benefit period.

[1]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.
[2]Non covered discounts may not be available in all states.
[3]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
[4]Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

Key Definitions
Copayment - The fixed amount paid by the member under the plan. Providers should collect all copayments
Allowance - Dollar amount to be applied toward the cost of materials or a service
Reimbursement - Dollar amount to be paid to the member from Aetna up to the providers' billed charge
Out-of-Pocket - The amount the member must pay after benefits have been applied
Discount - Percentage off the providers billed charge or retail cost
Standard Polycarbonate - 1.5 mm center thickness with spherical curves
Standard Scratch-Resistant Coating - Front-side factory scratch coat
Standard Progressive Lens - Multi-focal design that produce a gradual change in focus without lines or junctions
Conventional Contact Lens - Lenses intended for ongoing, daily-wear use; rigid gas-permeable lenses are included
Disposable Contact Lens - Lenses that are designed and labeled to be replaced at specified time intervals (e.g., daily, weekly, monthly)
Medically Necessary Contact Lenses - To correct visual acuity to 20/40 or better if such correction is not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. Contact your claims administrator for details. Coverage is not provided for the following:
• Special vision procedures, such as orthoptics, vision therapy, or vision training.
• Vision services that are covered in whole or in part; under any other part of this plan; or under any other plan of group benefits provided by the policyholder; or under any workers' compensation law or any other law of like purpose.
• For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
• Replacement of lost, stolen or broken prescription lenses or frames.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

PRESCRIPTION DRUG BENEFITS

THIS BOOKLET DOES NOT CONTAIN A PRESCRIPTION PLAN OR PRESCRIPTION BENEFITS, OTHER THAN WHAT MAY BE LISTED AS A COVERED MEDICAL BENEFIT.

DENTAL PLAN

NO DENTAL BENEFITS ARE COVERED UNDER THIS PLAN OTHER THAN STATED IN THIS BOOKLET.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable, at least part of it must be a covered service under this Plan. Allowed charges/services will be paid at the Allowed Amount.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. If the HMO is the Primary Plan that does not permit the services of Out of Network Providers with the exception of urgent care and/or medical emergency and the service provided by the Out of Network Provider is not considered as urgent care and/or medical emergency; then the Secondary Plan shall pay the eligible benefits as if the Plan was Primary.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. The New Jersey Auto Insurance Reform Act (Fair Act) (Personal Injury Protection). Effective January 1, 1991, resident New Jersey drivers who have new or renewing automobile policies issued in the state of New Jersey and are Active Employees covered under a group health plan have the right to designate their automobile policy's PIP (Personal Injury Protection) or their group health insurer as their primary payer for medical expenses incurred as a result of an automobile accident.

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

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

Should the employee elect the group health plan as secondary payer, the Plan will be liable for the deductible, coinsurance, and eligible expenses not covered by PIP within the cap chosen by the insured and eligible expenses above the PIP cap to the same extent as any other service and subject to all of the applicable contract provisions and limitations.

Out of State Automobile Insurance Coverage (OSAIC) means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile policies issued in another state or jurisdiction.

Generally, benefits under this Plan are secondary to OSAIC coverage, which means that this Plan will pay benefits after OSAIC. However, if the OSAIC coverage contains a provision, which makes it secondary to excess to this Plan, then this Plan will pay before the OSAIC.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the

stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

BY THIS AGREEMENT, Lumberton Board of Education, School's Health Insurance Fund is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Lumberton Board of Education on or as of the day and year first below written.

By DocuSigned by: Tyler Bright AFA7A86C1DCF42B... Tyler Bright

Title EBS CSB

Date 3/23/2023 | 11:01 AM EDT

Aetna Choice POS II $10

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