

Exhibit B

Horizon BCBSNJ: NJ DIRECT15 – Local Government Retiree

Summary of Benefits and Coverage: What this Plan Covers & What It Costs



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.state.nj.us/treasury/pensions/health-benefits.shtml or by calling 1-609-292-7524.

Important Questions		Answers	Why this Matters:
What is the overall deductible?		\$100 person/\$250 family for out-of-network services only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?		No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?		Yes. In-network coinsurance limit \$400 person/\$1,000 family; medical out-of-pocket limit \$5,028 person/\$10,056 family. Out-of-network \$2,000 person/\$5,000 family. Rx \$1,572 person/\$3,144 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?		Premiums, balance billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?		No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?		Yes. For a list of in-network providers, see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?		No. You don't need a written referral to see a specialist.	You can see the in-network specialist you choose without permission for this plan.
Are there services this plan doesn't cover?		Yes.	Some of the services this plan doesn't cover are listed on page 5 & 6. See your policy or plan document for additional information about excluded services.

Questions: Call 1-609-292-7524 or visit us at www.state.nj.us/treasury/pensions/health-benefits.shtml.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-609-292-7524 to request a copy.

Horizon BCBSNJ: NJ DIRECT15 – Local Government Retiree Summary of Benefits and Coverage: What this Plan Covers & What it Costs



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	30% coinsurance after deductible	— none —
	Specialist visit	\$15 copay/visit	30% coinsurance after deductible	— none —
	Other practitioner office visit	\$15 copay/visit	30% coinsurance after deductible	Chiropractic care is limited to 30 visits combined per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	— none —
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	Requires pre-approval

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need to see a doctor for a condition, you may need to get a prescription or have a procedure done.	Generic drugs	\$14 copay/30 day supply at a retail pharmacy; \$14 copay/90 day supply by mail order	In-network copays apply. You are responsible for any charges above the allowed amount.	Utilization Management programs may apply.
	Preferred brand drugs	\$27 copay/30 day supply at a retail pharmacy; \$41 copay/90 day supply by mail order	In-network copays apply. You are responsible for any charges above the allowed amount.	Utilization Management programs may apply.
	Non-preferred brand drugs	\$54 copay/30 day supply at a retail pharmacy; \$68 copay/90 day supply by mail order	In-network copays apply. You are responsible for any charges above the allowed amount.	Utilization Management programs may apply.
	Specialty drugs	Brand or generic copayments apply	Not Covered	Utilization Management programs may apply. Specialty drugs are only available by mail order.
If you have a condition that requires surgery or a procedure, you may need to see a doctor or have a procedure done.	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	_____ none _____
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	_____ none _____
	Emergency room services	\$50 copay/visit	\$50 copay/visit	Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	10% coinsurance	30% coinsurance after deductible	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
If you have a condition that requires a procedure, you may need to see a doctor or have a procedure done.	Urgent care	\$15 copay/visit	30% coinsurance after deductible	_____ none _____
	Facility fee (e.g., hospital room)	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate \$200 deductible per inpatient stay for out-of-network facilities.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
Prenatal care, delivery and postnatal care	Physician/surgeon fee	No Charge	30% coinsurance after deductible	Requires pre-approval
	Mental/Behavioral health outpatient services	\$15 copay/visit	30% coinsurance after deductible	Some specialty outpatient services require pre-approval. Inpatient services require pre-approval. There is a separate \$200 deductible per inpatient stay for out-of-network facilities.
	Mental/Behavioral health inpatient services	No Charge	30% coinsurance after deductible	
	Substance use disorder outpatient services	No Charge	30% coinsurance after deductible	
	Substance use disorder inpatient services	No Charge	30% coinsurance after deductible	Copayment applies to initial visit only.
Delivery and all inpatient services	Prenatal and postnatal care	\$15 copay/visit	30% coinsurance after deductible	Requires pre-approval. There is a separate \$200 deductible per inpatient stay for out-of-network facilities.
	Delivery and all inpatient services	No Charge	30% coinsurance after deductible	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have serious physical health issues:	Home health care	No Charge	30% coinsurance after deductible	Requires pre-approval.
	Rehabilitation services	\$15 copay/visit	30% coinsurance after deductible	Requires pre-approval.
	Habilitation services	\$15 copay/visit	30% coinsurance after deductible	Requires pre-approval.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate \$200 deductible per inpatient stay for out-of-network facilities.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Requires pre-approval for all rentals and some purchases.
If you or child needs dental or eye care:	Hospice service	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate \$200 deductible per inpatient stay for out-of-network facilities.
	Eye exam	\$15 copay/visit	Not Covered	Limited to one exam every 12 months.
	Glasses	Not Covered	Not Covered	_____ none _____
	Dental check-up	Not Covered	Not Covered	_____ none _____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	
• Cosmetic surgery	• Long-term care
• Dental care (Adult)	• Private-duty nursing (inpatient)
	• Routine foot care
	• Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|---|--|
| • Acupuncture (for pain management only) | • Hearing aids (Only covered for members age 15 or younger, maximums apply) | • Non-emergency care when traveling outside the U.S. (subject to deductible/coinsurance and balance billing) |
| • Bariatric surgery (requires pre-approval) | • Infertility treatment (requires pre-approval) | • Routine eye care (Adult) |
| • Chiropractic care (limited to 30 visits/year) | | |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-414-SHBP (7427). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cdcio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-414-SHBP (7427). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-609-292-7524.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-609-292-7524 or visit us at www.state.nj.us/treasury/pensions/health-benefits.shtml.

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Horizon BCBSNJ: NJ DIRECT15 – Local Government Retiree Coverage Examples

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: All Coverage Types | Plan Type: PPO
New Jersey State Health Benefits Program

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,360
- Patient pays \$180

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$30
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$180

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,270
- Patient pays \$1,130

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,500
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$1,050
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,130

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Horizon BCBSNJ: NJ DIRECT15 – Local Government Retiree Coverage Examples

Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: All Coverage Types | Plan Type: PPO
New Jersey State Health Benefits Program

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Exhibit C



OXFORD HEALTH INSURANCE, INC.
 Platinum PPO 2010 - Non-Guard
 SUMMARY OF COVERAGE
 The Group Name
 Liberty Network

BENEFIT **IN-NETWORK** **OUT-OF-NETWORK**

FINANCIAL			
Deductible:	Single Family	None None	\$1,000 \$2,000
Coinsurance:		None	30%
Maximum Out-Of-Pocket:	Single Family	\$2,000 \$4,000	\$4,000 \$8,000
Financial Accumulation Period:		Contract Year	Contract Year
Out of Network Reimbursement:		Not Applicable	High UCR

Please Note: All Copayments, Deductibles, and Coinsurance (reduced and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.

PREVENTIVE CARE

Adult Preventive Care	No Charge	Deductible then 30% Coinsurance
Infant and Pediatric Preventive Care	No Charge	Deductible then 30% Coinsurance
Preventive Dental for Children (Up to age 19)**	\$100 Deductible then No Charge	Deductible then No Charge
Pediatric Vision Exam (Up to age 19)	\$20 copay per visit	Deductible then 30% Coinsurance
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Deductible then 30% Coinsurance

OUTPATIENT CARE

Primary Care Physician Office Visit	\$20 copay per visit	Deductible then 30% Coinsurance
Specialist Office Visit	\$40 copay per visit	Deductible then 30% Coinsurance
Outpatient Surgery - Hospital Setting**	\$150 copay per visit	Deductible then 30% Coinsurance
Outpatient Surgery - Freestanding Facility**	No Charge	Deductible then 30% Coinsurance
*Outpatient Surgery Non-Network Limited to \$2,000.		
Laboratory Services**	No Charge	Deductible then 30% Coinsurance
Radiology Services**	No Charge	Deductible then 30% Coinsurance

MRI, MRSA, CT SCANS, AND PET SCANS

Outpatient Hospital Services**	\$100 copay per service	Deductible then 30% Coinsurance
Freestanding Radiology Facility**	\$50 copay per service	Deductible then 30% Coinsurance

HOSPITAL CARE

Physician's and Surgeon's Services**	No Charge	Deductible then 30% Coinsurance
Semi-Private Room and Board**	No Charge	Deductible then 30% Coinsurance
All Drugs and Medication	No Charge	Deductible then 30% Coinsurance

EMERGENCY CARE

Ambulance Service When Medically Necessary	No Charge	No Charge
All Hospital Emergency Room (unless if admitted)	\$100 copay per visit	\$100 copay per visit
(If member is admitted to the hospital, notification is required.)		
Emergency Care in Urgi-Care	\$40 copay per visit	Deductible then 30% Coinsurance

MATERNITY CARE

Prenatal and Post-Natal Care**	No Charge	Deductible then 30% Coinsurance
Hospital Services for Mother and Child**	No Charge	Deductible then 30% Coinsurance

SKILLED NURSING FACILITY**

120 days per Calendar Year Non-Network, Combined with Inpatient Rehabilitation	No Charge	Deductible then 30% Coinsurance
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HOSPICE CARE

Inpatient Care**	No Charge	Deductible then 30% Coinsurance
Home Hospice - Unfunded**	No Charge	Deductible then 30% Coinsurance

HOME HEALTH CARE

Home Care Visits - 60 visits per Calendar Year**	No Charge	Deductible then 30% Coinsurance
Physician Home Care	\$40 copay per visit	Deductible then 30% Coinsurance

SUBSTANCE USE DISORDER SERVICES

Inpatient Rehabilitation**	No Charge	Deductible then 30% Coinsurance
Outpatient Rehabilitation	\$40 copay per visit	Deductible then 30% Coinsurance

MENTAL HEALTH CARE

Inpatient Care**	No Charge	Deductible then 30% Coinsurance
Outpatient Visit	\$40 copay per visit	Deductible then 30% Coinsurance

BENEFIT **IN-NETWORK** **OUT-OF-NETWORK**

ALLERGY CARE Testing and Treatment**	\$40 copy per visit	Deductible then 30% Coinsurance
ALTERNATIVE MEDICINE Chiropractic Care - 30 Visits per Calendar Year**	\$50 copy per visit	Deductible then 30% Coinsurance
SHORT TERM RESIDUAL & REHABILITATIVE SERVICES Limited to 120 inpatient days Non-Network per Calendar Year. Coordinated with SNHHS Nursing	No Charge	Deductible then 30% Coinsurance
Outpatient Visits - limited to 30 combined PT/OT visits per calendar year (combined with Rehabilitation Services). Prescription upon initial visit**	\$40 copy per visit	Deductible then 30% Coinsurance
DURABLE MEDICAL EQUIPMENT Durable Medical Equipment - Unrestricted** Prescription required for items over \$100	No Charge	Deductible then 30% Coinsurance
MEDICAL SUPPLIES Medical Supplies When Medically Necessary	No Charge	Deductible then 30% Coinsurance
HEARING AIDS Hearing Aids (Age 18 & under) - Limited to 1 hearing aid for each hearing impaired ear every 14 months.	No Charge	Deductible then 30% Coinsurance
Hearing Aids (Age 18 & over) - Limited to \$5,000 for each hearing impaired ear every 14 months.	No Charge	Deductible then 30% Coinsurance
EXERCISE FACILITY Subscriber	\$200 reimbursement per 6 month period	\$300 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period

OUTPATIENT PRESCRIPTION DRUGS - RETAIL

The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductibles and/or maximum limits.

Tier 1	\$10 copy	Covered at participating pharmacies only
Tier 2	\$15 copy	Covered at participating pharmacies only
Tier 3	\$30 copy	Covered at participating pharmacies only

OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER

Tier 1	\$20 copy	Covered at participating pharmacies only
Tier 2	\$30 copy	Covered at participating pharmacies only
Tier 3	\$100 copy	Covered at participating pharmacies only

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

**These services require preauthorization through Oxford. Members must call Oxford at 1-800-444-6221 at least 15 days in advance of request of treatment to request preauthorization.

**Medical tests and laboratory services can be preauthorized through Oxford's Behavioral Health Department by calling 1-800-361-6991.

**Preauthorization is required for Poststyle Outpatient services only.

Please Note: This summary of coverage is provided for informational purposes only. The complete Summary of Benefits is to be provided to eligible members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate. Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, weight loss, dental care, personal care or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, or other services stated, dental services and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.

The OCA fee schedule for covered charges meets or exceeds an out-of-network benefit is either the allowed charge or actual charge. Allowed charge means a standard based on the 80th percentile in the prevailing market for charges payable for New Jersey or other state where services or supplies are provided in such state. In paying benefits for prosthetic and orthotic appliances, reimbursement will be at the same rate as reimbursement for such appliances under the Federal Medical reimbursement schedule.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com/oxford or by calling 1-800-444-6222.

Important Questions	Answers	Why this Matters
What is the overall deductible?	Non-Network: \$1,000 Individual/\$2,000 Family Per Calendar Year. Copays, pharmacy drugs, and services listed below as "No Charge" do not apply to the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$2,000 Individual/\$4,000 Family Non-Network: \$4,000 Individual/\$8,000 Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see welcometouhc.com/oxford or call 1-800-444-6222.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

¹ Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.

Questions: Call 1-800-444-6222 or visit us at oxfordhealth.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cds.cms.gov/ohr/healthreform or call 1-800-444-6222 to request a copy. This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing).
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	30% co-ins after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$40 copay per visit	30% co-ins after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$30 copay per visit	30% co-ins after ded	Cost share applies for only Manipulative (Chiropractic) Services and is limited to 30 visits per calendar year. Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
If you have a test	Preventive care/screening/immunization	No Charge	No Charge	\$750 OON max (under 1 yr old). \$500 OON max (1yr and over) per calendar year. Immunizations Non-Network. Subject to coinsurance. Includes preventive health services specified in the health care reform law.
	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins after ded	Pre-Authorization required Non-Network for Sleep Studies or benefit reduces to 50% of allowed

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at oxfordhealth.com .	Imaging (CT/PET scans, MRIs)	\$100 copay per service	30% co-ins after ded	Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Tier 1 - Your Lowest-Cost Option	Retail: \$10 copay Mail Order: \$20 copay	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail Order: Up to a 90-day supply. Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: \$25 copay Mail Order: \$50 copay	Not covered	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost
	Tier 3 - Your Highest-Cost Option	Retail: \$50 copay Mail Order: \$100 copay	Not covered	—none—
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	Tier is Not Applicable for this Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay per visit	30% co-ins after ded	Non-Network limited to \$2,000 per calendar year. Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Physician/surgeon fees	No Charge	30% co-ins after ded	—none—
	Emergency room services	\$100 copay per visit	\$100 copay per visit	—none—
If you need immediate medical attention	Emergency medical transportation	No Charge	30% co-ins after ded	—none—
	Urgent care	\$40 copay per visit	30% co-ins after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% co-ins after ded	Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Physician/surgeon fee	No Charge	30% co-ins after ded	—none—

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay per visit	30% co-ins after ded	—none—
	Mental/Behavioral health inpatient services	No Charge	30% co-ins after ded	Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Substance use disorder outpatient services	\$40 copay per visit	30% co-ins after ded	—none—
	Substance use disorder inpatient services	No Charge	30% co-ins after ded	Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
If you are pregnant	Prenatal and postnatal care	\$20 copay per visit (per initial visit)	30% co-ins after ded	Network routine prenatal care covered at No Charge. Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	No Charge	30% co-ins after ded	Inpatient Authorization may apply.
	Home health care	No Charge	30% co-ins after ded	Limited to 60 visits per calendar year. Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
If you need help recovering or have other special health needs	Rehabilitation services	\$40 copay per outpatient visit	30% co-ins after ded	Depending on the type of therapy, there is a limit of 60 visits per calendar year (combined with Habilitative services). Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Habilitative services	\$40 copay per outpatient visit	30% co-ins after ded	Pre-Authorization required for certain services. Non-network or benefit reduces to 50% of allowed. Services provided under and limits are combined with Rehabilitation Services above.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	No Charge	30% co-ins after ded	Limited to 120 days per calendar year Non-Network Combined with Inpatient Rehabilitation. Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
	Durable medical equipment	No Charge	30% co-ins after ded	Pre-Authorization required for items over \$500
	Hospice service	No Charge	30% co-ins after ded	Inpatient Pre-Authorization required for Non-Network or benefit reduces to 50% of allowed
If your child needs: dental or eye care	Eye exam	\$20 copay per visit	50% co-ins after ded	Limited to one exam every 12 months. Covered for Individuals up to the age of 19.
	Glasses	50% co-ins	50% co-ins after ded	Limited to one pair every 12 months. Covered for Individuals up to the age of 19.
	Dental check-up	0% co-ins after \$100 ded indiv / \$200 ded family.	0% co-ins after ded	Limited to one exam and cleaning per 6 month period. Covered for Individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Long-term care	• Routine eye care (Adult)
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply
- Chiropractic care

Coverage Example

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-444-6222. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or ebsa.hhs.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or the New Jersey Department of Banking and Insurance at 1-800-446-7467 or state.nj.us/dobi/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

- Para obtener asistencia en Español, llame al 1-866-633-2446.
- 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.
- Dinak'ebgo shika at'ohwol nisisingo, kwijigo holne 1-866-633-2446.
- Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Coverage Example

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is
not a cost
estimator.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,320
- Patient pays \$220

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$220

Managing type 2 diabetes (routine maintenance of an insulin-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,260
- Patient pays \$1,140

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$1,100
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,140

Coverage Example

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the examples.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

* No. Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

* No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-444-6222 or visit us at oxfordhealth.com. If you aren't clear about any of the underlined terms used in this plan, see the Glossary. You can view the Glossary at cdio.cms.gov or dol.gov/ebsa/healthreform or call 1-800-444-6222 to request a copy. This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Exhibit D



OXFORD HEALTH INSURANCE, INC.
 Planform EPO 15/10 - Non-Credit
SUMMARY OF COVERAGE
 The Group Name
 Liberty Network

BENEFIT **IN-NETWORK** **OUT-OF-NETWORK**

FINANCIAL			
Deductible**	Single Family	None None	Not Covered Not Covered
Coinurance		None	Not Covered
Maximum Out-Of-Pocket: (Including Deductible)	Single Family	\$2,500 \$5,000	Not Covered Not Covered
Financial Acceleration Period		Contract Year	Not Applicable
Out-Of-Network Reimbursement		Not Applicable	Not Applicable

Please Note: All Copayments, Deductibles, and Coinsurance (incident and participating) p/d for In-Network Covered Services and this is the In-Network, Out-Of-Pocket Maximum.

PREVENTIVE CARE			
Adult Preventive Care		No Charge	Not Covered
Infant and Pediatric Preventive Care		No Charge	Not Covered
Pre-Walve Dental for Children (Up to age 19)**		\$100 Deductible then No Charge	Not Covered
Pediatric Vision Exam (Up to age 19)		\$15 copay per visit	Not Covered
Pediatric Vision Refraction (Up to age 19)		50% Reimbursement	Not Covered

OUTPATIENT CARE			
Primary Care Physician Office Visit		\$15 copay per visit	Not Covered
Specialist Office Visit		\$40 copay per visit	Not Covered
Outpatient Surgery - Hospital Setting**		\$150 copay per visit	Not Covered
Outpatient Surgery - Freestanding Facility**		\$40 copay per visit	Not Covered
Laboratory Services**		No Charge	Not Covered
Radiology Services**		No Charge	Not Covered

INPATIENT CARE			
Occupational Hospital Services**		\$160 copay per service	Not Covered
Freestanding Radiology Facility**		\$50 copay per service	Not Covered

HOSPITAL CARE			
Physician's and Surgeon's Services**		No Charge	Not Covered
Semi-Private Room and Board**		\$250 copay per day, \$1,250 max per admission, \$1,500 max per Calendar Year.	Not Covered
All Drugs and Medication		No Charge	Not Covered

EMERGENCY CARE			
Ambulance Service When Medically Necessary		No Charge	Not Covered
All Hospital Emergency Room (ER) (if admitted) (If member is admitted to the hospital, no copayment is required)		\$100 copay per visit	\$100 copay per visit
Emergency Care in Urgi-Center		\$40 copay per visit	Not Covered

MATERNITY CARE			
Prenatal and Post-Natal Care**		No Charge	Not Covered
Hospital Services for Mother and Child**		\$250 copay per day, \$1,250 max per admission, \$1,500 max per Calendar Year.	Not Covered

SKILLED NURSING FACILITY**			
Unskilled		\$120 copay per day, \$1,250 max per admission, \$1,500 max per Calendar Year.	Not Covered

HOSPICE CARE			
Inpatient Care**		\$250 copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year.	Not Covered
Home Hospice - Unskilled**		\$10 copay per visit	Not Covered

HOME HEALTH CARE			
Home Care Visits - 60 visits per Calendar Year**		\$40 copay per visit	Not Covered
Physician Home Calls		\$30 copay per visit	Not Covered

SUBSTANCE USE DISORDER SERVICES			
Inpatient Rehabilitation**		\$250 copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year.	Not Covered
Outpatient Rehabilitation		\$40 copay per visit	Not Covered

DENTAL HEALTH CARE			
Inpatient Care**		\$250 copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year.	Not Covered
Outpatient Visit		\$10 copay per visit	Not Covered

MEMBER BENEFITS: IN-NETWORK OUT-OF-NETWORK

ALLERGY CARE Testing and Treatment**	\$10 copy per visit	Not Covered
ALTERNATIVE MEDICINE Chiropractic Care - 30 Visits per Calendar Year**	\$30 copy per visit	Not Covered
SHORT TERM RESIDUAL & HABILITATIVE SERVICES Inpatient Visits - Unlimited	\$150 copy per day, \$1,250 max per admission, \$3,500 max per Calendar Year	Not Covered
Outpatient Visits - Limited to 30 combined PT/OT visits per calendar year (combined with Rehabilitative Services). Prescription upon initial visit**	\$40 copy per visit	Not Covered
DURABLE MEDICAL EQUIPMENT Durable Medical Equipment - Unlimited** Prescription required for items over \$500	No Charge	Not Covered
MEDICAL SUPPLIES Medical Supplies When Medically Necessary	No Charge	Not Covered
HEARING AIDS Hearing Aids (Age 18 & over) - Limited to 1 hearing aid for each hearing required once every 24 months.	No Charge	Not Covered
Hearing Aids (Age 18 & over) - Limited to \$5,000 for each hearing required once every 24 months.	No Charge	Not Covered
EXERCISE FACILITY Subscriber	\$100 reimbursement per 6 month period	Not Covered
Spouse	\$100 reimbursement per 6 month period	Not Covered

OUTPATIENT PRESCRIPTION DRUGS - RETAIL

The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductible and for maximum limits.

Tier 1	\$10 copy	Covered at participating pharmacies only
Tier 2	\$15 copy	Covered at participating pharmacies only
Tier 3	\$50 copy	Covered at participating pharmacies only

OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER

Tier 1	\$20 copy	Covered at participating pharmacies only
Tier 2	\$50 copy	Covered at participating pharmacies only
Tier 3	\$100 copy	Covered at participating pharmacies only

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

**These services require preauthorization through Oxford. Members must call Oxford at 1-800-444-6122 at least 30 days in advance of request of treatment to request preauthorization.

**Mental health and substance use disorder services can be preauthorized through Oxford's Behavioral Health Department by calling 1-800-701-4991.

**Preauthorization is required for Podiatry/Oncology services only.

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate. Refer to the Certificate of Coverage for a more complete listing of all benefits, exclusions, and limitations which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal medical or commercial travel, private or special duty nursing, hearing and behavioral disorders, WorkLife Change center, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and its regulations may be subject to change.

A This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com/oxford or by calling 1-800-444-6222.

Important Questions	Answers	Why this Matters
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other deductibles	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: \$2,500 Individual/\$5,000 Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see welcometouhc.com/oxford or call 1-800-444-6222.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

¹ Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.

Questions: Call 1-800-444-6222 or visit us at oxfordhealth.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at ehc.oxfordhealth.com/ehc/glossary or call 1-800-444-6222 to request a copy. This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay per visit	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$40 copay per visit	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$30 copay per visit	Not covered	Cost share applies for only Manipulative (Chiropractic) Services and is limited to 30 visits per calendar year
	Preventive care/screening/immunization	No Charge	Not covered	Includes preventive health services specified in the health care reform law. No Coverage Non-Network
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not covered	Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed
	Imaging (CT/PET scans, MRIs)	\$100 copay per service	Not covered	---none---

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at oxfordhealth.com	Tier 1 - Your Lowest-Cost Option	Retail: \$10 copay Mail Order: \$20 copay	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail Order: Up to a 90-day supply. Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: \$25 copay Mail Order: \$50 copay	Not covered	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost.
	Tier 3 - Your Highest-Cost Option	Retail: \$50 copay Mail Order: \$100 copay	Not covered	—none—
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	Tier is Not Applicable for this Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay per visit	Not covered	—none—
	Physician/surgeon fees	No Charge	Not covered	—none—
	Emergency room services	\$100 copay per visit	\$100 copay per visit	—none—
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	—none—
	Urgent care	\$40 copay per visit	Not covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	—none—
	Physician/surgeon fee	No Charge	Not covered	—none—

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay per visit	Not covered	—none—
	Mental/Behavioral health inpatient services	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	—none—
	Substance use disorder outpatient services	\$40 copay per visit	Not covered	—none—
	Substance use disorder inpatient services	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	—none—
If you are pregnant	Prenatal and postnatal care	\$15 copay per visit (per initial visit)	Not covered	Network routine prenatal care covered at No Charge. Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	\$40 copay per visit	Not covered	Limited to 60 visits per calendar year.
	Rehabilitation services	\$40 copay per outpatient visit	Not covered	Depending on the type of therapy, there is a limit of 60 visits per calendar year (combined with Habilitative services).
	Habilitative services	\$40 copay per outpatient visit	Not covered	Services provided under and limits are combined with Rehabilitation Services above.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	—none—
	Durable medical equipment	No Charge	Not covered	Pre-Authorization required for items over \$500
	Hospice service	\$250 copay per day. \$1,250 max per admission. \$2,500 max per calendar year	Not covered	—none—
If your child needs dental or eye care	Eye exam	\$15 copay per visit	Not Covered	Limited to one exam every 12 months. Covered for Individuals up to the age of 19.
	Glasses	50% co-ins	Not Covered	Limited to one pair every 12 months. Covered for Individuals up to the age of 19.
	Dental check-up	0% co-ins after \$100 ded indiv / \$200 ded family.	Not Covered	Limited to one exam and cleaning per 6 month period. Covered for Individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Long-term care	• Routine eye care (Adult)
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - limitations may apply
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply
- Chiropractic care

Coverage Example

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-444-6222. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or ebsa.hhs.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or the New Jersey Department of Banking and Insurance at 1-800-446-7467 or state.nj.us/dobi/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

- Para obtener asistencia en Español, llame al 1-866-633-2446.
- 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.
- Dinekt'ehgo shika a'ohwol ninisingo, kwijigo bolne! 1-866-633-2446.
- Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Coverage Example

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,840
- Patient pays \$700

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$500
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$700

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,360
- Patient pays \$1,040

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$1,000
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,040

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the examples.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

*** No.** Treatments shown are just examples.

The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

*** No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Exhibit E



Mark L. Gravinese, Administrator
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mlgravinese@harristwp.us

Diana L. Malloy
Registered Municipal Clerk
Phone: 856-478-4111/Fax: 856-478-2498
dmalloy@harristwp.us

Township of Harrison
114 Bridgeton Pike
Mullica Hill, NJ 08062

Louis Manzo, Mayor
Dennis Clowney, Deputy Mayor
Matt Diggons, Committeeman
Don Heim, Committeeman
Robert Shearer, Committeeman

March 12, 2015

Dear Sgt. George Marra,

Attached please find the formal response and supporting documentation from Grievance Hearing (Step C) that was held on Monday, March 2nd. In addition, there are supporting documentation from the hearing and copy of supporting documentation from Step B of the Grievance process.

As noted in my voice message on Thursday, March 12, in addition to this electronic version, I have also sent a hardcopy to you via certified mail.

Thank You,

Mark L. Gravinese
Township Administrator
Harrison Township



mlgravinese@harristwp.us
(856) 478-2164

CC: Mayor/Public Safety Director Louis Manzo
Deputy Mayor Dennis Clowney
Committeeman Robert Shearer
Committeeman Matt Diggons
Committeeman Don Heim
Deputy Twp. Administrator Dennis Chambers
Police Chief Tom Mills
PBA – Officer Brent Datz
Edward Selb
Joe Marchei
Christine Kemp
George Polizza



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Don Heim, Committeeman
Robert Shearer, Committeeman

To: Sgt. George Marra (Ret) – Complainant
Patrolman Brent Datz – PBA Local 178 President
Chief Thomas Mills

From: Louis Manzo - Mayor/Public Safety Director

Subject: Grievance Hearing

Date: March 11, 2015

On March 2, 2015, I chaired a Hearing in Closed Session of the Harrison Township Committee. This meeting took place in compliance with the Grievance Procedure outlined in Article IV Section 1 of the collective bargaining agreement with our Local PBA #178. This Hearing satisfies Step C of that process. The history and all previously completed steps are detailed in the attached report titled *Grievance – Step B- Complete*.

Present at this meeting in addition to myself were: Deputy Mayor Dennis Clowney, Committeemen Don Heim, Matt Diggins and Bob Shearer, Twp Administrator Mark Gravinese, Twp Deputy Administrator Dennis Chambers, Twp Solicitor Brian Duffield and Twp Clerk Diane Malloy. Chief Tom Mills and PBA Representative, Kurt Pfulgfelder, were also present as required by the protocol. The Complainant, George Marra was present and spoke on behalf of the other remaining grieved parties (Ed Selb, Joe Marchei, Christine Kemp and George Politza). Present in addition to Mr. Marra were: Joe Marchei and his wife, Nora, George Politza, Elizabeth Selb (Ed Selb's wife) and Ed Selb (who arrived toward the end of the Hearing).

I began by stating that the objective of the Hearing was for Township Committee to "make all reasonable attempts to reach a settlement that is satisfactory to all parties", as stated in Step C of the Grievance Procedure. I also confirmed with the Complainant that the only "satisfactory settlement" from his perspective was for Township Committee to reverse their decision to change the Health Benefits Plan in its entirety.

Given the floor, the Complainant referred to a hypothetical example provided in the Oxford Plan Summary (new plan) as proof that the new plan violated the "equal to or better than" clause of our

contract with the PBA, based on the "patient out-of-pocket" figures in the example. There was some discussion about the voracity of those figures and whether they were "generic" to all Oxford Plans or specific to the Plan actually being used.

The Complainant then made the point that Township Committee had the opportunity to address the "equal to or better than clause" and the fact that retirees received paid benefits for life in the collective bargaining negotiations in the past ten years or so ("3 opportunities" was referenced). This prompted my response on two fronts: First I restated Township Committee's position on the "equal to or better than clause", which is that we were not seeking to eliminate or circumvent it. In fact, we proceeded in our research from the outset to ensure that we would meet the standard of that clause in any new plan considered. In addition it was never our goal to undo the "paid health benefits for life" clause in the contract. So the suggestion that we should have introduced eliminating either clause in any contract negotiation wasn't and isn't in line with the Committee's objectives.

Instead, we focused on what the contract language referencing any change in benefits actually states:

"The Township may change retirement health coverage provided that the new benefits and doctor/hospital co-pays are equal to or better than those offered by the Township as of the date the employee retired."

I reiterated our understanding of that language that the "new benefits AND doctor/hospital co-pays" meet the "equal to or better than" standard. Obviously the word "and" is the key to our approach of comparing the Health Benefit Plans from an overall perspective (Co-pays, Deductibles, Out-of-Pocket Costs AND the Benefits provided). The Complainant restated his position that "benefits" and "co-pays" stand alone and separately. That led to some discussion about the new plan and what the Complainant considered "medical" benefits. The Complainant stated that Dental and Vision are not medical benefits and that he considers those benefits as "ancillary".

The Complainant called on Elizabeth Selb to read a written statement from her husband Ed (attached as Selb Statement), as well as adding some additional thoughts of her own. Based on that input, we feel compelled to respond to certain points for clarification purposes.

- The statement contained a section titled Notification. Clearly this section is intended to convey Mr. Selb's dissatisfaction with the fact that the retirees were not included in the process of considering a change in health benefits. That's understood and we have explained the "process" that actually took place and how it precluded us (Township Committee) from directly interacting with the retirees on this matter. Therefore, for clarification, the statement that we "were under limited authority to notify him" is incorrect, in our opinion. At all times during this process, the Twp. Committee was in direct communication with PBA reps. Based on the protocols of negotiations/conversations with the existing leadership of PBA Local 178, we had NO authority to go outside that process and notify Mr. Selb or any other retiree.
- The statement that "we found out by almost mistake that it was going to occur" is a misperception. After Township Committee had decided to move forward with the benefits change, a retiree happened to interact in the Municipal Building with Mark Gravinese, Township Administrator. Mr. Gravinese had just been charged with officially notifying all current employees and retirees of our decision and his notice had not been sent out yet. As a courtesy, Mr. Gravinese gave this retiree a "heads up" that this notice was

coming. So the situation referenced was actually an advance notice to the official notice, which the retiree was to receive along with everyone else.

- The entire section in the Notification paragraph pertaining to dates is confusing to me since I don't know if Mr. Selb has all those dates/facts straight, so I won't address it here but would be happy to discuss it upon clarification. Suffice it to say that there was no intent to mislead or exclude the retirees, as is implied.
- The statement "at the insurance broker meeting the mayor stated that he and other administration were being an advocate for the people involved, employees, officers, etc. never mentioning the retired officers" and any reference to what an advocate is and the retired officers being "an afterthought" is misguided. At the insurance broker meeting referenced, I was speaking to a room with ONLY retirees as an audience; so I was listing the other groups (employees, current officers, etc.) effected by the change in addition to the current audience. It wasn't meant as a slight. Any advocacy pertaining to health benefits on our part would always be on behalf of all participants, current or retired.
- This feeling of being excluded is also indicated when referencing the insurance broker meeting the Township held with all the current employees. Mr. Selb states, "again there was no notice or intent to notice the retired officers." This is factual. It was always our intent to have separate meetings. We did not think it prudent to include retirees in the same meeting with current employees since retirees do not contribute to the cost of their health benefits. The insurance broker presentation for current employees included a great deal of information on premium costs and contribution levels which would have been a waste of time for the retirees.
- All references to "Agenda" items that are meant to imply an intent to hide the health benefits issue from anyone is once again misguided. The facts are that we originally hoped to have everything resolved for a January 1, 2015 implementation, considering we had started our research earlier in 2014 and began our interaction with the PBA in August of 2014. By the time we entered mid-January 2015, we had obviously missed the January 1st objective and we were cutting it close for an April 1st start date. At that point, we would not seek to move forward until all issues and questions were resolved with the PBA and they had given us written confirmation of their support for the change; which had not yet occurred. The receipt of that written confirmation came at a time when the Agenda for the January 21, 2015 meeting was already published. Given the urgency to proceed once we received written PBA confirmation, waiting two more weeks until the next Township Committee meeting to officially take action was, frankly, never a consideration. That's why it wasn't included on the printed Agenda.
- The last point of the Notification section references ""after going through the grievance procedure, we are told that we didn't notify you in time for the next step". Agreed. Clearly, this was an oversight as our Administrator did not see a line at the end of an email from the Complainant that asked about the next step in the procedure. As soon as that was brought to light, we immediately scheduled the Step C Hearing. Our apologies for this mistake, but there was no intent to break the protocol of the Grievance Procedure that we have followed to the letter thus far.
- Mr. Selb's statement includes a section titled Equal. He is correct that I have stated "line by line" no one health insurance plan could ever be *equal to or better than* any other health insurance plan on EVERY line when you consider that the Plan Summaries of these plans are sometimes an inch thick. I've also stated, as Mr. Selb says, that the true/best comparison is an "overall" comparison. Mr. Selb states "by admission of the mayor, dental and eye care are not considered health care". I believe he is referring to my

statement at the broker meeting that "long term care (LTC)" does not fall under health care rules/laws, so he either misheard or I misspoke because I would never knowingly say Dental/Vision are "not considered health care". I'm knowledgeable enough on the topic to know that this is not a matter of opinion. Dental and Vision Care are considered health benefits. Tying Mr. Selb's point here to the Complainant's statement that Dental and Vision Care are ancillary, I point to the current plan in Harrison Township under which all employees and retirees receive their coverage as an example. It can be viewed on the State of New Jersey's website and it is called the State Health Benefits Program (SHBP). It includes various Plans, called Medical, Dental, Vision, etc. Dental and Vision are, by definition, health care; as is Medical. Long Term Care and Disability Insurance are not.

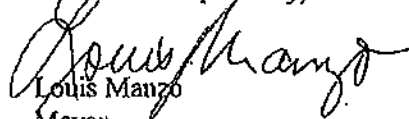
- Lastly, pertaining to Mr. Selb's statement, the final line of the Notification section reads: "Through the entire process, there has been consistent effort made to hide, bury, under handedness and a lack of transparency on the part of the township." Factually, this could not be further from the truth. The fact that we engaged the local PBA leadership in August 2014 and added substantial benefits to the new plan specifically to ensure adherence to the "equal to or better than" clause illustrates our transparency. The unanimous support by the voting members of the PBA in January 2015 (6 months later) also confirms that. It's not within the control of Township Committee to direct the internal communication of a union.

It should be noted that at one point in this Hearing, Elizabeth Selb officially requested a disclosure of the premium savings in the new plan and requested that any money saved on the retiree's premium be paid out to them. She later withdrew that official request so it's stated here only to provide a reference point on the different perspectives that exist on this topic. The premiums paid by the Township for their Health Benefits are a matter of public record and were reviewed in the meetings with the current employees since they pay for a portion of their benefits. There has never been an attempt to conceal those numbers.

As the Hearing concluded, it was confirmed that the retirees see the change in Health Benefits initiated by the Township as a violation of the "equal to or better than" clause. Period. This is based on their exclusion of the Dental Plan as part of the Health Benefit coverage and they place no value on it.

It is, therefore, a unanimous decision of the Harrison Township Committee to deny the Complainant's request to reverse the change in Health Benefits in its entirety. Further, it is the opinion of the Township Committee, along with the unanimous consent by PBA Local 178, that the new health benefit plans, in totality, are equal to or better than the existing health benefit coverage.

Submitted Respectfully,


Louis Manzo
Mayor
Public Safety Director

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March 17, 2015

Via Fax (856-478-6955), Email (Brian.Duffield@comcast.net) and Regular Mail

Brian J. Duffield, Esquire
Solicitor, Harrison Township
95 N. Main Street
Mullica Hill, NJ 08062

Re: Harrison Township Breach of Police Contract

Dear Mr. Duffield:

I represent Edward Selb, George Marra, George Politza, Christine Kemp, and Joseph Marchei, retired Harrison Township officers. As you may know, Harrison Township is scheduled to cancel its existing healthcare contract with Horizon Blue Cross/Blue Shield on April 1, 2015 - two weeks from today - and replace it with a contract with Oxford/United Healthcare. Upon comparing the plans, it is clear that the Oxford plans are not "equal to or better than" the existing Horizon plan, which violates the collective bargaining agreement in place when these officers retired.

The officers have been going through the grievance process as required by the collective bargaining agreement. On March 12, 2015, "Part C" of the grievance procedure terminated with a decision from the Harrison Township Committee to deny the relief requested. Part D of the procedure requires the parties to submit to arbitration. However, because the current contract expires at the end of this month, and several plaintiffs have doctors who are not covered by the Oxford plans, irreparable harm will result from proceeding with the grievance procedures in the usual fashion.

American Arbitration Association rules permit arbitrators to issue preliminary injunctions if permitted by the parties. Plaintiffs are amenable to empowering an arbitrator to decide if a preliminary injunction should issue before April 1st. However, this would require us to quickly agree on an arbitrator and submit moving papers. If the Township is willing, the Plaintiffs are willing to take the necessary steps to get a

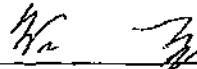
WBIR & PARTNERS LLP
A Pennsylvania Limited Liability Partnership

decision before the current contract expires. The other option is to file an Order to Show Cause with the Superior Court, if you feel that we are unable to have an arbitrator decide whether to issue a preliminary injunction before the end of the month.

Please contact me as soon as possible with your answer. This matter is extremely time-sensitive. If we do not receive an answer by the end of the day tomorrow, March 18, 2015, we will proceed by filing the matter in the Superior Court.

Thank you for your attention to this matter. Please contact me with any questions that you have.

Very truly yours,
WBIR & PARTNERS LLP



Wesley Fenza, Esquire

cc: Ed Selb
George Politza
Christine Kemp
George Marra
Joseph Marchei