TOWNSHIP OF WEST MILFORD

NORTH JERSEY MUNICIPAL EMPLOYEE BENEFITS FUND

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

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INTRODUCTION

This document is a description of the plan of benefits for the Township of West Milford (the Plan) through the North Jersey Municipal Employee Benefits Fund. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. All of the self-insured plans offered for the Township of West Milford through the North Jersey Municipal Employee Benefits Fund are included in this document. Each Plan will have distinctive provisions. Please refer to the Schedule of Benefits including limits, cost management and exclusions for each Plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason; subject to the Fund By-laws and in compliance with any applicable bargaining unit agreements.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like; subject to the necessary approvals.

This document contains plan(s) that are considered a "**grandfathered**" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov. This web-site will provide information on which protections do not apply to grandfathered health plans.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursements from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Participants and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.
This part should be read carefully since each Participant may be required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

This Plan shall also provide, contrary or more effective language notwithstanding, those coverages that the statutes and administrative regulations of the State of New Jersey require a Municipality, member of the North Jersey Municipal Employee Benefits Fund to provide to an Employee, Dependent or COBRA participant as the case may be.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

Coverage under this Plan is based on the status of the Participant (Employee/Retiree/Dependent) and the completion of any applicable Waiting Period.

ELIGIBILITY

Eligible Classes of Employees.

The following Classes of Employees:

(1) All Full Time Active Employees of the Employer

(2) Certain Retired Employees who retire under the criteria of and participates in a State of New Jersey administered retirement system and / or in accordance with a collective bargaining unit agreement(s).

(3) Elected Officials as sanctioned by the Municipal Entity.

(4) Eligibility as described and approved by Township Resolution.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is an Full Time or Permanent Part Time Active Employee of the Employer. An Employee is considered to be Full-Time or Permanent Part Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is an Active Employee under an in force collective bargaining agreement between the Township of West Milford and the collective bargaining unit.

(3) is a Retired Employee of the Employer who directly retires under the criteria of and participates in a State of New Jersey administered retirement system and fulfills the eligibility requirements of the Township of West Milford and / or in accordance with a collective bargaining unit agreement.

(4) is in a class eligible for coverage.

(5) is an Elected Official as sanctioned by the Municipal Entity.

(6) is eligible as described and approved by Township Resolution.

(7) completes the employment Waiting Period of two (2) full calendar months as an Active Employee.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. Coverage begins the first day of the month following the completed Waiting Period.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) Medical and Prescription Coverage:

A covered Employee's Spouse:

The term "**Spouse"** shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

The term "**Civil Union Partner**" shall mean the person of the same sex who is the covered Employee's civil union partner in the state or municipality that recognizes civil unions and extends to civil union partners the same legal rights, protections and obligations available to spouse's.

A covered Employee's Child(ren).

The term **"child(ren)"** shall include natural child(ren), stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

Foster Child means an unmarried child under the limiting age whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's: the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction. A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

The phrase "**placed for adoption**" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Qualified Medical Child Support Order (QMCSO):

A child of an *Employee* who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and

- You request coverage for the child in writing with a copy of the court order.

Coverage will be effective on the date of the court order.

If a covered Employee is a Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried and is covered under the plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals, subsequent proof of the child's Total Disability and dependency.

The plan reserves the right to have such Dependent examined by a Physician of the Plan's Choice, at the Plan's expense, to determine the existence of such incapacity.

(2) Dental Coverage

A covered Employee's Spouse and unmarried children from two years of age to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after the age of 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 23. When the child reaches either limiting age or marries, coverage will end at the end of the Calendar Month. If the child does not maintain full-time student status or graduates, coverage ceases independent of the limiting age.

Full time student coverage continues between semester quarters only if the student is enrolled as a full-time student in the next regular semester / quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

If both parents are Employees and eligible for coverage under this plan, both employees may enroll under this Plan and their eligible child(ren) may be covered as Dependents of both employees. Benefits will never exceed 100% of eligible covered charges.

Eligibility Requirements for Medicare Eligible Persons. The following provisions explain how this plan interacts with the benefits available under Medicare Secondary Payer rules. A member may be eligible for Medicare by reason of age, disability or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility.

A Member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches the age of 65. This plan is considered the primary health plan for any Member who is an Active Full-Time employee. Upon retirement, Medicare will become the primary payer. ***Participants are required to enroll in Medicare Part A & Part B by the first day of the Calendar Month following thirty days of the qualifying event if eligible for enrollment during the Medicare Special Enrollment period***, or during the next available Medicare Open Enrollment period (January 1st through March 31st of each year to be effective by the following July 1st) following the qualifying event.

This plan requires that Covered Persons who are eligible for Medicare by reason of disability must be enrolled under Medicare Part A / Hospital Insurance and Part B / Medical Insurance in order to be a participant under this plan. This plan cannot pay for benefits which should be paid by Medicare. Benefits will be payable as specified under the Coordination of Benefits Provisions of this plan. (see section for Coordination of Benefits).

Eligibility Requirements for Medicare Eligible Persons Due to End Stage Renal Disease (ESRD*).*

When a member becomes eligible for Medicare solely on the basis of ESRD, this plan will be the primary payer for a period of 30 consecutive months for any charges incurred for the treatment of ESRD services and supplies.

The 30-month period begins on the earlier of:

(1) the first day of the month during which a regular course of renal dialysis starts; and

(2) with respect to an ESRD Medicare eligible person who receives a kidney transplant, the first day of the month during which such Member becomes eligible for Medicare.

After the 30-month period described above ends, Medicare will become the primary payer and this plan will pay secondary.

Participants are required to enroll in Medicare Part A & Part B by the first day of the Calendar Month following thirty days of the qualifying event if eligible for enrollment during the Medicare Special Enrollment period, or during the next available Medicare Open Enrollment period (January 1st through March 31st of each year to be effective by the following July 1st) following the qualifying event.

A Retired Employee must follow the same rules for enrollment in the Plan as Full – Time Active Employee. It is the Retired Employee's responsibility to notify the Plan of any changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage will not take place until the Retired Employee has formally requested the change in writing. A Retired Employee may change plans (if applicable) during open enrollment.

GROUP MEDICARE ADVANTAGE PPO PLAN

All Medicare eligible Retirees and Disabled Persons shall enroll in the Group Medicare Advantage PPO Plan with Prescription Drug. You must continue paying your Medicare Part B premiums to maintain this coverage. If you stop paying your Medicare Part B premium, or you choose to opt out of the Medicare Advantage PPO Plan, your retiree coverage under the fund will terminate and you will lose your employer – sponsored coverage. You will retain your entitlement to your original Medicare Parts A and B. If your employer – sponsored medical coverage under the Fund terminates, you will not be able to re-enroll at a later date. The carrier will provide the plan summary for the Group Medicare Advantage PPO Plan with Prescription Drug. Medicare eligible participants and / or Medicare eligible dependents do not need to enroll in Medicare Part D prescription drug coverage.

FUNDING

Eligible Full-Time Active Employees: The Township of West Milford may share the cost of the Employee and Dependent coverage under this Plan with the employee.

The Township of West Milford establishes the levels of Employee contributions. The Township of West Milford reserves the right to change the level any required contributions unless otherwise stipulated, based on individual bargaining unit agreements and / or Plan Sponsor contractual agreements.

Eligible Retired Employees: Certain retired employees, who meet defined requirements, may receive pre-determined base plan(s) of benefits at no cost or, depending upon the eligibility requirements of the retiree, may share in the cost of the plan. An eligible retired employee may have the option to enroll in a non-base plan(s) and contribute towards the costs of these plans. If the eligible Retired Employee is paying any of the costs for coverage, the premiums will be billed on a monthly basis or as otherwise established by the North Jersey Municipal Employee Benefits Fund.

An Eligible Retired Employee coverage is based on meeting the following defined requirements:

(1) the eligible Retiree receives retirement benefits from a State of New Jersey administered retirement system; and

(2) the eligible Retiree has twenty-five or more years of service credited with a State or Locally Administered plan; or who has retired and reached the age of 62 years or older with at least 15 years of service with this Employer; or

(3) the eligible Retiree retired on an approved Disability Retirement (regardless of year of service) in that retirement system;

The Employer has agreed to continue coverage of a surviving Spouse of an eligible Retiree who qualified under the provisions listed above. The surviving Spouse will be billed for the premiums either monthly or quarterly.

Coverages for surviving Spouse will end the last day of the month, which the surviving Spouse remarries.

The Township of West Milford establishes the levels of Retiree contributions. The Township of West Milford reserves the right to change the level any required contributions.

A Retired Employee may remove family members from this Plan at any time but may only add members within 60 days of the change in family status (marriage, birth of a child, etc.). It is the Retired Employee's responsibility to notify the Township of West Milford of the changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium, if any) will not take place until the Retired Employee has formally requested the change.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application, which may also require a payroll deduction form for contributions, if applicable. If an Employee does not enroll or does not enroll eligible Dependents, the Employee must wait until the next open enrollment period.

A Covered Person may remove eligible Dependents from this Plan at any time, but may only add eligible Dependents with 60 days of the change in family status (i.e. marriage, birth, etc.). It is a person's responsibility to notify the Township of West Milford of additions, deletions or changes which may have occurred that could impact eligibility and coverage. If an eligible Dependent ceases to be eligible, claims will not be paid. The actual change in coverage and any corresponding change in premium contributions, (if any) will not take place until the covered employee has formally requested the change by completing an enrollment change form.

Enrollment Requirements for Newborn Children. A newborn child of a covered employee shall be automatically covered from birth for thirty-one (31) days but must be enrolled in the plan.

Newborn and child dependent coverage shall not extend to grandchildren of the Employee except in the case where the grandchild is placed in adoption with the Employee or the Employee has been granted court ordered guardianship and properly enrolled. The plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn children (including grandchildren) to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from pre-maturity, the newborn children must be enrolled as a Dependent under this Plan within sixty (60) days from the child's birth for coverage to take effect. However, a newborn child shall be automatically covered for thirty-one (31) days of the child's birth even if not enrolled within the required sixty (60) days. An enrollment form for the child must be completed to add the child as a Dependent. If the newborn child is not enrolled in this plan within the 60 days following the date of birth, the enrollment will not be considered timely and there will be no payment from the Plan and the parents will be responsible for all costs. (*See Timely Enrollment Section Below*).

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment –** If two Employees (mother and father of dependent child(ren) are covered under the Plan and the Employee who is covering the Dependent child(ren) terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment –** An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The enrollment date for a Late Enrollee is the first day of coverage. The time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins January 1st.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the birth, marriage, adoption or placement for adoption. The covered employee must provide the applicable required supporting documentation for the qualifying life event.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Township of West Milford, 1480 Union Valley Road, West Milford, New Jersey, 07480.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employer or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), or

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for this eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 60 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 60-day period.

The coverage of the Dependent and / or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

(4) Completes the Waiting Requirement.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect. An employee will be considered Actively at Work if either the Employee is performing the regular duties of employment on that day at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business.

An employee is considered to be Actively at Work on each day of a regular paid vacation and on each regular non-work day on which the Employee is unable to perform the essential function of the job, if the Employee was Actively at work on the last preceding regular work day.

If the Employee is absent from work due to the inability to perform the essential functions of the job on the date this plan would otherwise have been effective, the effective date will be deferred until the date on which the Employee returns as an Active Employee.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The date the covered Employee’s Employer ceases to be a covered Employer.

(4) The last day of the pay period or 30 days following the last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Full-Time Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The day the covered Employee enters the military, navy or air force of any country or international organization on an active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

(7) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends continuance.

For leave of absence or layoff only: the date the Employer ends continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

New Jersey Family Leave Act. Pursuant to the Family Leave Act (N.J.S.A. 34:11B-a,et seq.), most employees who have worked at least 1000 hours during the last 12 months are eligible to receive an unpaid leave of absence for a period not to exceed 12 weeks in a 24-month period.

Leave may be taken in connection with the birth or adoption of a child, or the serious health condition of a family member (i.e., child, parent, or Spouse).

Any leave granted to an eligible employee under this Act due to the serious health condition of a family member may be taken consecutively or intermittently, depending upon the legitimate needs of the employee. Any leave granted due to the birth or adoption of a child must be taken consecutively unless otherwise agreed to by the employer and must begin within one year of the adoption or birth.

The Act does not require an employer to grant more than 12 weeks of leave in any consecutive 24-month period. However, family leave granted under the Act is in addition to, and separate from, any right granted under the "Temporary Disability Benefits Law."

Eligible employees must provide prior notice to the employer, in compliance with the Act, if requesting a leave of absence under this Act. The employer has the right to request that an employee provide a certification issued by a health care provider in order to ensure that the employee meets the eligibility requirements.

The employer may deny a request for leave made by an otherwise eligible employee, if the employee is among the highest paid five percent, or is one of the seven highest paid employees of the company, whichever is greater, and the employer can demonstrate that the leave will cause substantial and grievous economic injury to its operations

Federal Family and Medical Leave Continuation. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment-waiting period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated

(2) The date Dependent coverage under the Plan is terminated.

(3) The date that the Employee’s coverage under the Plan terminates for any reason including death. (See

the section entitled Continuation Coverage Rights under COBRA).

(4) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA).

(5) Coverage for a Dependent Child will end:

For **Medical and Prescription Coverage**: On the last day of the Calendar Year in which a Dependent child reaches the limiting age of 26. (See the section entitled Continuation Coverage Rights under COBRA).

For **Dental Coverage**: On the last day of the Calendar Month in which a Dependent child reaches the limiting age of nineteen (19), or twenty-three (23) if a full-time student or the if the Dependent child marries.

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(7) The date the covered Dependent enters the military, navy or air force of any country or international organization on an active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

(8) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage or benefits under the Plan, or fails to notify the Town of Dover that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retro actively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action.

Conversion Privilege. Employees, eligible Retirees and eligible Dependents may purchase individual coverage, under an individual direct payment basis if their loss of group health coverage is due to any reason other than voluntary termination. A person may obtain information by contacting the appropriate Department of Insurance in the state in which a person will have or has established residence. Such individual coverage options are also available when the maximum period of COBRA coverage has expired.

OPEN ENROLLMENT

Every October, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every October, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless:

1) there is a Special Enrollment event or

2) a change in family status during the year (birth, death, marriage, divorce, adoption) or

3) the Employee or Spouse has taken a leave of absence or

4) the Employee or Spouse had a change in employment status or

5) loss of coverage due to loss of a Spouse's employment or

6) there has been a significant change in the Spouse’s health insurance coverage.

To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

In Case of Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in**:**

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies are:

- Heart attack or suspected heart attack
- Loss of consciousness
- Poisoning
- Suspected overdose of medication
- Severe shortness of breath
- Severe burns
- Uncontrolled or sever bleeding
- High fever (especially in infants)

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Follow-Up Care After Emergencies

Follow-up care is not considered an emergency or urgent condition **and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.**

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **physician**.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible and payment percentage** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice:

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Sore throat
- Fever
- Earaches

Follow-up care provided by your Physician **is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully, subject to the specialist copay shown in the "Schedule of Benefits"**.

What to Do Outside Your Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions at "referred care" levels. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent

medical condition that occurs outside your service area can be treated in any of the above settings. You should call your Physician as soon as possible after receiving treatment.

If, after reviewing information submitted to by the doctors who provided care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the following procedures for a person receiving benefits for an appropriate mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy if applicable.

or answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1) The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

   - The service or supply must be provided while coverage is in effect.

2) The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   - In accordance with generally accepted standards of medical practice;

   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and

   - Not primarily for the convenience of the patient, **physician** or other health care provider;

   - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note:

Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example: some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

AETNA MEDICAL PLANS

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

Verification of Eligibility: Refer to back of member ID card

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

Aetna Provider Networks

- **Patriot V Plan – QPOS**
- **Open Access Plan – Health Network Options**
- **Preferred Plan – Choice POS II**
- **HDHP – Choice POS II**

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 Claim Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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 bargaining unit contracts, date of hire, or participant contributions.

Call the number on the ID card to verify eligibility for Plan benefits before the charge is incurred.

AETNA NAVIGATOR

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator through the Aetna website home page or directly via www.aetnanavigator.com.

With Aetna Navigator, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the **Aetna Provider Network.**
- Check the status of a claim

- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services

HOW YOUR MEDICAL PLAN WORKS

It is important that you have the information and useful resources to help you get the most out of your **Aetna** Open Access plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.

Common Terms

Many terms throughout this Booklet are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

AETNA QPOS MEDICAL PLAN

How the Plan Works

The Choice Is Yours

The Quality Point-of-Service (QPOS) Plan offers you the convenience and cost savings of a health maintenance organization (HMO)-type plan with the freedom and flexibility of a traditional medical plan. You have access to a network of Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

As a QPOS Plan participant, you have a choice each time you need medical care:

Referred Care

When your PCP provides your care, or refers you to a participating specialist or hospital, you receive the maximum benefits available under the Plan for covered services. After making a copayment for certain types of care, you have no further out-of-pocket expenses, up to the limits shown in the "Schedule of Benefits."

Self-Referred Care

You can directly access doctors or hospitals of your choice without a referral from your PCP. Your care is "self-referred" if you don't obtain care from your PCP or a referral from your PCP … ***even if you choose a provider in the QPOS network***. The Plan covers self-referred care, but your expenses will be higher:

- You must satisfy an annual **deductible** before the Plan begins to pay benefits.

- Once you've met the deductible, you must pay a portion of the covered self-referred expenses you incur (your **self- referred coinsurance** share), up to the **self-referred out-of-pocket maximum**. The self-referred out-of-pocket maximum controls your annual self-referred expenses. Your deductible does not apply toward the self-referred out- of-pocket maximum.

- **Out of Network providers** have not agreed to accept the negotiated charge. Aetna will reimburse you or your provider for a covered expense incurred from an **out of network provider** up to the **recognized charge** and the maximum benefits under this Plan, less any cost sharing required by you such as deductibles and payment percentage or coinsurance. The recognized charge is the maximum amount **Aetna** will pay for a **covered expense** from an **out of network provider.** If your **out of network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge.** Except for emergency services, Aetna will only pay up to the **recognized charge**.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Your PCP provides basic and routine care, and will help you access appropriate care.

Consult your PCP whenever you have questions about your health. When medically necessary, your PCP will refer you to other doctors or facilities for treatment. Except for PCP, direct access, and emergency services, **you must have a prior written or electronic referral from your PCP to receive the Plan's highest level of coverage for**

all services and any necessary follow-up treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You are responsible only for the copayment shown in the "Schedule of Benefits."

Coverage for self-referred primary and preventive care is limited. Refer to the "Schedule of Benefits" for details.

Specialty and Facility Care

Referred

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment [or coinsurance] shown in the "Schedule of Benefits."

To avoid costly and unnecessary bills, follow these steps:

- Always **consult your PCP first** when you need medical care. If they deem it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan.

- Certain services require **both** a referral from your PCP **and** precertification from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.

- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.

- Present the referral to the provider. Any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services covered at the Plan's higher level of coverage. **Without the referral, you will be subject to the annual deductible, coinsurance and maximum benefits shown in the "Schedule of Benefits," even if you visit a network provider.**

- On occasion, your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers ***require prior approval by Aetna*** in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) before seeking specialty or hospital care.

Self-Referred

Seeking the advice of your PCP before visiting a specialist or hospital can minimize your out-of-pocket expenses and help you find appropriate care more quickly. The Plan offers you the option, however, of going directly to a specialist or hospital for non-emergency care, without obtaining a prior referral from your PCP. When you self-refer, you will be subject to the self-referred deductible, coinsurance and maximum benefits shown in the "Schedule of Benefits." You must also obtain any necessary precertification, and you will probably have to file a claim form for reimbursement.

If the doctor or hospital you visit directly is part of the QPOS network, you may reduce your out-of-pocket medical expenses. Your coinsurance will be based on Aetna's fee schedule, which is often substantially lower than standard billed rates.

AETNA OPEN ACCESS MEDICAL PLANS

About Your Aetna Open Access Medical Plans

Your Aetna Open Access plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. With your Aetna Open Access plan, you can directly access any **network** or **out-of-network physician**, **hospital** or other health care provider for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers** under this plan.

Important Note:

Network providers have contracted with **Aetna**, to provide health care services and supplies to **Aetna** plan members. **Network providers** are generally identified in the on-line version of the provider **directory** which can be accessed via DocFind at www.aetna.com unless otherwise noted in this section. **Out-of-network providers** are not listed in the **Aetna directory**.

Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions*, *Limitations* sections and *Schedule of Benefits* to determine if medical services are covered, excluded or limited.

The Aetna Open Access medical plans provide access to covered benefits through a broad network of health care providers and facilities. This Aetna medical plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **out of pocket expenses** will generally be lower when you use **network providers** and facilities.

You also have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network** providers because the **deductibles** and **payment percentage** (coinsurance) that you are required to pay are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.

Your out-of-pocket costs may vary between network and out-of-network benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are **covered expenses**. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Reporting of Claims* and the *Claims and Appeals* sections of this Booklet.

To better understand the choices that you have with your Aetna Open Access plan, please carefully review the following information.

The Primary Care Physician

Please Note: Under the Aetna Open Access Medical Plans, selection of a PCP is optional and NOT required.

To access network benefits, you are ***encouraged*** to select a **Primary Care Physician (PCP**) from **Aetna**'s network of providers. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory by contacting Member Services through e-mail or by calling the toll-free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on Aetna's website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna's** receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** and other health care professionals in the network for covered services and supplies. Refer to the **Aetna provider directory** to locate network **specialists, providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to our plan.

Important Note:

ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians, hospitals** and **other health care** providers and facilities.

- If a service or supply you need is covered under this Plan but not available from a **network provider** in your area, please contact Member Services at the toll-free number on your ID card for assistance.

- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **payment percentage** and **copayments**, if any.

- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, **copayments**, or **payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will provide reimbursement for a **covered expense,** incurred from a **network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.

- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits

- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers.**

- For certain types of services and supplies, you will be responsible for any **copayments** shown in your *Schedule of Benefits*. The **copayments** will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a **specialist** or non-**specialist.** You will be subject to the **PCP copayments** shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **network provider.** If the provider is a **network specialist**, then the **specialist copayment** will apply.

- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limit** applicable to your plan.

- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limits**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.

- You may be billed for any **deductible**, **copayment**, or **payment percentage** amounts, or any non-covered expenses that you incur where applicable.

Accessing Out-of-Network Providers and Benefits

- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your provider may **precertify** the services for you. However, you should verify with **Aetna** prior to the service, that the provider has obtained **precertification** from **Aetna**. If the service is not **precertified**, the benefit payable may be reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.

- When you use **out-of-network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to **Aetna** for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to an **out-of-network provider**.

- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, or **payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call Member Services if you have questions regarding your statement.

Important Note
Failure to **precertify** services and supplies will result in a reduction of benefits or no coverage for the services or supplies under this Booklet. Please refer to the *Understanding Precertification* section for information on how to request **precertification**.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Out-of-network providers** have not agreed to accept the **negotiated charge. Aetna** will reimburse for a **covered expense,** incurred from an **out of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage.** The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.

- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.

- **Deductibles** and **payment percentage** are usually higher when you use **out of network providers** than when you use **network providers.**

- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limits** that apply to your plan.

- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.

- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.

AETNA MEDICAL PLANS – PRECERTIFICATON

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below.

Important Note:

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient **medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.

For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient, non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved, the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna**'s decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Claims and Appeals section.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice** facility
- Outpatient **hospice care**
- **Stays** in a **Residential Treatment Facility** for treatment of mental disorders and substance abuse
- **Partial Hospitalization Programs** for mental disorders and substance abuse
- **Acupuncture**
- **Durable Medical Equipment (in excess of $500)**
- **Emergency Services**
- **Home health *care***;
- **Home Infusion Therapy**

- **Hospice Care**
- **Infertility Services**
- **MRI/Cat Scans**
- **Pain Management Services**
- **Private Duty Nursing**
- **Short Term Therapies: Cardiac Rehabilitation, Respiratory Therapy, Occupational, Physical and Speech Therapy, Radiation and Chemotherapy**
- **Transplant Services**

Intensive Outpatient Programs for mental disorders and substance abuse;

- **Applied Behavioral Analysis**;
- **Neuropsychological testing**; **Psychological testing**
- **Outpatient detoxification**;
- **Psychiatric home care services**.

AETNA MEDICAL PLANS – SCHEDULE OF BENEFITS

AETNA Patriot V QPOS NETWORK GRANDFATHERED	NETWORK PROVIDERS REFERRALS REQUIRED	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	$100
Per Family Unit	N/A	$200
COPAYMENTS		
Hospital services	100% coverage	70% after deductible
Physician visits	$5 copay	70% after deductible
Outpatient services	100% coverage	70% after deductible
Emergency room	$25 copay waived if admitted	$25 copay waived if admitted 70% after deductible
Urgent Care Facility	$5 copay	70% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	N/A	$2,000
Per Family Unit	N/A	$4,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the recognized charge for Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Copayments Amounts over recognized charge		
COVERED CHARGES		
Hospital Services		
Room and Board	100% coverage semiprivate room rate	70% after deductible semiprivate room rate
Intensive Care Unit	100% coverage	70% after deductible
Maternity Unit	100% coverage semiprivate room rate	70% after deductible semiprivate room rate
Skilled Nursing Facility Calendar Year maximum	100% coverage facility's semiprivate room rate no day limit	70% after deductible facility's semiprivate room rate 240 days and 35 physician visits
Diagnostic Testing Outpatient XRay and Lab Tes Complex Imaging Services	100% coverage	70% after deductible
Physician Services		
Inpatient visits	100% coverage	70% after deductible
Office visits	$5 copay	70% after deductible
After Hour / Home visits	$10 copay	70% after deductible
Surgery	100% coverage	70% after deductible
Allergy testing	$5 copay	70% after deductible
Allergy serum and injections	$5 copay	70% after deductible
Home Health Care	100% coverage	70% after deductible
Outpatient Private Duty Nursing	100% coverage	70% after deductible
Hospice Care	100% coverage	70% after deductible

AETNA Patriot V QPOS NETWORK GRANDFATHERED	NETWORK PROVIDERS REFERRALS REQUIRED	NON-NETWORK PROVIDERS
Ambulance Service	100% coverage	70% after deductible
Jaw Joint/TMK Precertification required	Refer to physician services and surgical benefits	Refer to physician services and surgical benefits
Wig After Chemotherapy	100% coverage	70% after deductible
Benefit maximum	$500 every 24-month period – Combined In and Out of Network	
Occupational Therapy	$5 copay based on medical review	70% after deductible based on medical review
Speech Therapy	$5 copay based on medical review	70% after deductible based on medical review
Physical Therapy	$5 copay based on medical review	70% after deductible based on medical review
Chemotherapy	100% coverage	70% after deductible
Radiation Therapy	100% coverage	70% after deductible
Infusion Therapy	100% coverage	70% after deductible
Durable Medical Equipment requires precertification over $1500	100% coverage	70% after deductible
Prosthetics requires precertification	100% coverage	70% after deductible
Orthotics **Requires precertification**	100% coverage	70% after deductible
Spinal Manipulation/Chiropractic Calendar Year maximum	$5 copay 60 visits	70% after deductible based on medical review
Mental Disorders and Substance Abuse		
Inpatient	100% coverage	70% after deductible
Residential Treatment Facility	100% coverage	70% after deductible
Outpatient	$5 copay	70% after deductible
Alcohol Abuse		
Inpatient Residential Treatment Facility Outpatient Outpatient Detoxification Rehabilitation	100% coverage 100% coverage $5 copay $5 copay $5 copay	70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Preventive Care		
Routine Well Adult Care Calendar Year maximum	$5 copay 1 visit per year	Not covered
Routine GYN Calendar Year Maximum	$5 copay 1 visit	70% after deductible
Routine Mammogram	100% coverage	70% after deductible
• Preventive Benefits includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for mammogram Age 35 through 39 . . . . . one baseline exam Ages 40 and over . . . . . annually		

AETNA Patriot V QPOS NETWORK GRANDFATHERED	NETWORK PROVIDERS REFERRALS REQUIRED	NON-NETWORK PROVIDERS
Routine Well Child Care	$5 copay	Not covered
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations through age 12.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months.	100% coverage	70% after deductible
Routine Eye Exam	$5 copay	Not covered
Eyeglasses/Contact Lenses Reimbursement	$70 every 24 months	Not covered
Organ Transplants	100% coverage	70% after deductible
Prescription Drugs	Deductible waived; 90% coverage until annual out-of-network maximum out-of-pocket is satisfied, then coverage at 100%	
Pregancy – Prenatal Care	$5 copay first visit only	70% after deductible
Infertility Benefits Office Visit Outpatient Services	Copay is based where services is provided. $ 5 copay 100% coverage	70% after deductible
(IVF GIFT ZIFT) Lifetime maximum	4 attempts – Combined In and Out of Network	
Includes: care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility.		

AETNA OPEN ACCESS 20 HEALTH NETWORK OPTIONS (HNO) GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	$300
Per Family Unit	N/A	$600
The Calendar Year deductible is waived for the following Covered Charges: - Preventive Care up to an annual maximum of $150		
COPAYMENTS		
Hospital services	100%	80% after deductible
Office visits	$20 copay	80% after deductible
Outpatient services	100%	80% after deductible
Emergency room	$100 copay waived if admitted	$100 copay waived if admitted
Urgent Care Facility	$25 copay	80% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	N/A	$2,000
Per Family Unit	N/A	$4,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the recognized charge for Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Copayments Amounts over the recognized charge		
COVERED CHARGES		
Hospital Services – pre-notifification required		
Room and Board	100% coverage the semiprivate room rate	80% after deductible the semiprivate room rate
Intensive Care Unit	100% coverage	80% after deductible
Maternity Unit	100% coverage the semiprivate room rate	80% after deductible the semiprivate room rate
Skilled Nursing Facility Calendar Year maximum	100% coverage facility's semiprivate room rate N/A	80% after deductible facility's semiprivate room rate 240 days and 35 physician visits
Diagnostic Testing Outpatient XRay and Lab Test Complex Imaging Services	100% coverage	80% after deductible
Physician Services		
Inpatient visits	100% coverage	80% after deductible
Office visits	$20 copay	80% after deductible
After Hour / Home visits	$25 copay	80% after deductible
Surgery	100% coverage	80% after deductible
Allergy testing/serum/injections	$20 copay	80% after deductible
Specialists	$25 copay	80% after deductible
Home Health Care	100% coverage	80% after deductible

AETNA OPEN ACCESS 20 HEALTH NETWORK OPTIONS (HNO) GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	100% coverage	80% after deductible
Ambulance Service	100% coverage	80% after deductible
Jaw Joint/TMJ	Refer to physician services and surgical benefits	Refer to physician services and surgical benefits
Wig After Chemotherapy	100% coverage	80% after deductible
Benefit Maximum	$500 every 24-month period – Combined In and Out of Network	
Occupational Therapy Calendar Year maximum	$20 copay 60 visits per 60 consecutive days period per illness or injury	80% after deductible based on medical review
Speech Therapy Calendar Year maximum	$20 copay 60 visits for 60 consecutive days period per illness or injury	80% after deductible based on medical review
Physical Therapy Calendar Year maximum	$20 copay 60 visits for 60 consecutive days period per illness or injury	80% after deductible based on medical review
Chemotherapy	100% coverage	80% after deductible
Infusion Therapy	100% coverage	80% after deductible
Radiation Therapy	100% coverage	80% after deductible
Durable Medical Equipment requires precertification over $1500	100% coverage	80% after deductible
Prosthetics requires precertification	100% coverage	80% after deductible
Orthotics requires precertification	100% coverage	80% after deductible
Spinal Manipulation / Chiropractic **Calendar Year Maximum**	$25 copay 40 visits	80% after deductible 20 visits
Mental Disorders and Substance Abuse		
Inpatient Rehabilitation Outpatient	100% coverage 100% coverage $25 copay	0-30 days 100%; 80% after deductible 0-30 days 100%; 80% after deductible 80% after deductible
Alcohol Abuse		
Inpatient Residentail Treatment Facility Outpatient Outpatient Detoxification	100% coverage 100% coverage $25 copay $25 copay	80% after deductible 80% after deductible 80% after deductible 80% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Preventive Care		
Routine Well Adult Care Calendar Year maximum	$20 copay 1visit	100% up to a combined maximum of $150; 80% after deductible thereafter

AETNA OPEN ACCESS 20 HEALTH NETWORK OPTIONS (HNO) GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine GYN Calendar Year Maximum	$25.00 copay 1 visit	100% up to a combined maximum of $150.00; 80% after deductible thereafter
Routine Mammogram	100% coverage	100% up to a combined maximum of $150.00; 80% after deductible thereafter
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for mammogram Age 35 through 39 . . . . . one baseline exam Ages 40 and over . . . . . annually		
Routine Well Child Care Calendar Year maximum	$20 copay N/A	100% up to a combined maximum of $150; 80% after deductible thereafter
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations through age 12.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	80% after deductible
Routine Eye Exam	$25 copay	Not covered
Eyeglasses/Contact Lenses Reimbursement	$70 every 24 months	Not covered
Organ Transplants	100% coverage	80% after deductible
Pregnancy – Prenatal Care	$25 first visit only	80% after deductible
Prescription Drugs	Deductible waived; 80% coverage until annual out-of-network maximum out-of-pocket is satisfied, then coverage at 100%	
Infertility Benefits Office Visit Outpatient Services (IVF GIFT ZIFT) Advanced Reproductive Technology (ART) 4 egg retrievals per lifetime	 $25 copay 100% coverage 4 attempts – Combined In and Out of Network Includes: care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility.	 80% after deductible 80% after deductible

AETNA CHOICE POS II PREFERRED PLAN NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Covered expenses accumulate toward both the Network and Non-Network Deductible.		
Per Covered Person	$500	$500
Per Family Unit	$1000	$1000
COPAYMENTS		
Hospital services	80% after deductible	60% after deductible
Physician visits	$20 copay	60% after deductible
Specialist	$40 copay	60% after deductible
Emergency room ***Non-Emergency care in the Emergency Room is not covered***	$100.00 copay; then 80% Deductible waived Copay waived if Admitted	$100.00 copay; then 80% Deductible waived Copay waived if Admitted
Urgent Care Facility	$40 copay	60% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Covered Network Expenses applied towards the Network Out of Pocket Maximum will also apply towards the Non-Network Out of Pocket Maximum		
Per Covered Person	$2000	$4000
Per Family Unit	$4000	$8000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which 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 out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Copayments Amounts in excess of the Recognized Charge		
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible semiprivate room rate	60% after deductible semiprivate room rate
Intensive Care Unit	80% after deductible	60% after deductible
Maternity Unit	- 80% after deductible semiprivate room rate	60% after deductible semiprivate room rate
Skilled Nursing Facility Calendar Year Maximum 240 Days	80% after deductible facility's semiprivate room rate	60% after deductible facility's semiprivate room rate
Hospice Facility	80% after deductible	60% after deductible
Private Duty Nursing **Out Patient** Precertification is required	80% after deductible	60% after deductible
Diagnostic Testing Outpatient XRay and Lab Test Complex Imaging Services	80% after deductible	60% after deductible
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	$20 copay	60% after deductible
After Hour / Home visits	$20 copay	60% after deductible
Specialist visits	$40 copay	60% after deductible
Surgery / Anesthesia	80% after deductible	60% after deductible

AETNA CHOICE POS II PREFERRED PLAN NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Allergy testing and treatment	$40 copay	60% after deductible
Home Health Care Calendar year maximum 120 visits	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
Ambulance Ground, Water or Air	80% after deductible	60% after deductible
Wig After Chemotherapy Maximum per 24 months - $500	80% coverage Deductible does not apply	60% after deductible
Occupational Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	60% after deductible
Physical Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	60% after deductible
Speech Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	60% after deductible
Chemotherapy - Outpatient	80% after deductible	60% after deductible
Radiation Therapy - Outpatient	80% after deductible	60% after deductible
Infusion Therapy - Outpatient	80% after deductible	60% after deductible
Dialysis - Outpatient	80% after deductible	60% after deductible
Durable Medical Equipment Requires precertification over $500	80% after deductible	60% after deductible
Prosthetics Requires precertification over $500	80% after deductible	60% after deductible
Orthotics Requires precertification over $500	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic Subject to Medical Review 30 visits per calendar year max	$40 copay	60% after deductible
Mental Disorders		
Inpatient Residential Treatment Facility Outpatient	80% after deductible 80% after deductible $40 copay	60% after deductible 60% after deductible 60% after deductible
Substance Abuse		
Inpatient Residential Treatment Facility Outpatient Outpatient Detoxification	80% after deductible 80% after deductible $40 copay $40 copay	60% after deductible 60% after deductible 60% after deductible 60% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Preventive Care		
Routine Well Adult Care 1 visit every 12 months 18 +	100% coverage	Covered up to $150 Preventative Care Max
Routine Gynecological Exam 1 visit per Calendar Year	100% coverage	Covered up to $150 Preventative Care Max
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		

Frequency limits for Mammogram Ages 35 through 39 . . . one baseline exam Ages 40 and over. . . . . .annually (includes 3D Mammogram)		
Frequency limits for Prostate Screening Age 40 and over…….one annual Prostrate screening		
Routine Eye Exam Benefit Maximum	100% coverage one exam every 24 months	Covered up to $150 Preventative Care Max
Routine Well Newborn Care Inpatient	100% coverage	Covered up to $150 Preventative Care Max
Routine Well Child Care	100% coverage	Covered up to $150 Preventative Care Max
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations.		
***Additional Preventative Care services shall be provided as required by the Affordable Care Act and provided by a Network Physician. Visit www.HealthCare.gov for a complete listing of covered services.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	60% after deductible
Prescription Drug Benefit	20% coinsurance card after deductible	20% coinsurance card after deductible
Prenatal Care		
First OB visit Subsequent Prenatal Visits	$20 copay 100% coverage	60% after deductible 60% after deductible
Organ Transplants	Payable in accordance with the type of expense incurred and the place where services provided.	60% after deductible
Infertility Services Office Visit Out-Patient Services Advanced Reproductive Technology Maximum of 4 egg retrievals per lifetime Lifetime Limit - $15,000	$40 copay 80% after deductible	60% after deductible 60% after deductible
Includes: care, supplies and services for the diagnosis of infertility and treatment for underlying medical cause of infertility.		

AETNA CHOICE POS II HIGH DEDUCTIBLE HEALTH PLAN NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maximum Lifetime Benefit	**Unlimited**	
DEDUCTIBLE, PER CALENDAR YEAR		
Covered expenses accumulate toward both the Network and Non-Network Deductible.		
Per Covered Person	$1350	$1350
Per Family Unit	$2700	$2700
COPAYMENTS		
Hospital services	80% after deductible	50% after deductible
Physician visits	80% after deductible	50% after deductible
Specialist	80% after deductible	50% after deductible
Emergency room ***Non-Emergency care in the Emergency Room is not covered***	80% after deductible	80% after deductible
Urgent Care Facility	80% after deductible	50% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Covered expenses accumulate toward both the Network and Non-Network Out of Pocket Maximum.		
Per Covered Person	$5500	$5500
Per Family Unit	$11,000	$11,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which 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 out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Copayments Amounts in excess of the Recognized Charge		
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible semiprivate room rate	50% after deductible semiprivate room rate
Intensive Care Unit	80% after deductible	50% after deductible
Maternity Unit	80% after deductible semiprivate room rate	50% after deductible semiprivate room rate
Skilled Nursing Facility Calendar Year Maximum 240 Days	80% after deductible facility's semiprivate room rate	50% after deductible facility's semiprivate room rate
Hospice Facility	80% after deductible	50% after deductible
Private Duty Nursing **Out Patient** Precertification is required	100% after deductible	50% after deductible
Diagnostic Testing Outpatient XRay and Lab Test Complex Imaging Services	80% after deductible	50% after deductible
Physician Services		
Inpatient visits	80% after deductible	50% after deductible
Office visits	80% after deductible	50% after deductible
After Hour / Home visits	80% after deductible	50% after deductible
Specialist visits	80% after deductible	50% after deductible
Surgery / Anesthesia	80% after deductible	50% after deductible
Allergy testing and treatment	80% after deductible	50% after deductible

AETNA CHOICE POS II HIGH DEDUCTIBLE HEALTH PLAN NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Home Health Care Calendar year maximum 120 visits	100% after deductible	50% after deductible
Hospice Care	80% after deductible	50% after deductible
Ambulance Ground, Water or Air	80% after deductible	50% after deductible
Wig After Chemotherapy Maximum per 24 months - $500	100% coverage Deductible does not apply	100% after deductible
Occupational Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	80% after deductible	50% after deductible
Physical Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	80% after deductible	50% after deductible
Speech Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	80% after deductible	50% after deductible
Chemotherapy - Outpatient	80% after deductible	50% after deductible
Radiation Therapy - Outpatient	80% after deductible	50% after deductible
Infusion Therapy - Outpatient	80% after deductible	50% after deductible
Dialysis - Outpatient	80% after deductible	50% after deductible
Durable Medical Equipment Requires precertification over $500	80% after deductible	50% after deductible
Prosthetics Requires precertification over $500	80% after deductible	50% after deductible
Orthotics Requires precertification over $500	80% after deductible	50% after deductible
Spinal Manipulation Chiropractic Subject to Medical Review 30 visits per calendar year max	80% after deductible	50% after deductible
Mental Disorders		
Inpatient Residential Treatment Facility Outpatient	80% after deductible 80% after deductible 80% after deductible	50% after deductible 50% after deductible 50% after deductible
Substance Abuse		
Inpatient Residential Treatment Facility Outpatient Outpatient Detoxification	80% after deductible 80% after deductible 80% after deductible 80% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Preventive Care		
Routine Well Adult Care 1 visit every 12 months 18 +	100% coverage	Not Covered
Routine Gynecological Exam 1 visit per Calendar Year	100% coverage	Not Covered

Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for Mammogram Ages 35 through 39 . . . one baseline exam Ages 40 and over. . . . . .annually (includes 3D Mammogram)		
Frequency limits for Prostate Screening Age 40 and over…….one annual Prostrate screening		
Routine Eye Exam Benefit Maximum	100% coverage one exam every 24 months	Not Covered
Routine Well Newborn Care Inpatient	100% coverage	Not Covered
Routine Well Child Care	100% coverage	Not Covered
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations.		
***Additional Preventative Care services shall be provided as required by the Affordable Care Act and provided by a Network Physician. Visit www.HealthCare.gov for a complete listing of covered services.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	50% after deductible
Prescription Drug	20% coinsurance card after deductible	20% coinsurance card after deductible
Prenatal Care		
First OB visit Subsequent Prenatal Visits	80% after deductible 100% coverage	50% after deductible 50% after deductible
Organ Transplants	Payable in accordance with the type of expense incurred and the place where services provided.	50% after deductible
Infertility Services Office Visit Out-Patient Services Advanced Reproductive Technology Maximum of 4 egg retrievals per lifetime Lifetime Limit $15,000	 80% after deductible 80% after deductible	 50% after deductible 50% after deductible
Includes: care, supplies and services for the diagnosis of infertility and treatment for underlying medical cause of infertility.		

AETNA MEDICAL PLANS – COVERED SERVICES

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.

Deductible

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

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

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% (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% (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.

Covered Charges

Covered Charges are eligible charges 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 Expenses

Hospital Care. *Covered medical expenses include services and supplies provided by a* ***hospital*** *during your stay.*

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include hospital charges for other services and supplies provided, such as:

- Medically Necessary **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

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

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.

Private Duty Nursing

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.

Important Reminders:

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your stay.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **payment percentage** and maximum benefit limits.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment for an **emergency medical condition**.

Important Reminder:

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- **Physician** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment of an **urgent condition**.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**

The surgery must meet the following requirements:

- The surgery can be adequately and safely only in a **surgery center** or **hospital**; and
- The surgery is not normally performed in a **physician's** office.

Important Note:

Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre and post-operative care and administration of anesthesia; and
- Services of another **physician** for related post – operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**
- Facility charges for office based surgery.

Birthing Center

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Home Health Care Services

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.

Covered expenses include charges made by a **home health care agency** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- Medical supplies and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had a **hospital stay**.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, **behavioral health provider** or therapist is 1 visit.

In figuring the Calendar Year Maximum Visits (if applicable), each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and

- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and

- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.

- Services of a person who usually lives with you, or who is a member of your or your spouse's family.

- Services of a certified or licensed social worker.

- Services for Infusion Therapy.

- Transportation.

- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.

- Services that are **custodial care**.

Important Reminders:
The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

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 expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
    - Assessment of your social, emotional and medical needs, and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;
    - Medical supplies;
    - Psychological counseling; and
    - Dietary counseling.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders:
Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.
Inpatient **hospice care** and home health care must be **precertified** by **Aetna**.

Other Medical Services and Supplies

These services and supplies not otherwise included in the items above are covered as follows:

Ambulance

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.

Ground Ambulance*:*

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a **hospital, skilled nursing facility** or acute rehabilitation **hospital,** an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance:

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

Limitations:
Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or

Contact Lenses

Initial contact lenses or glasses required following cataract surgery.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Diabetic test agents
- Insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips for glucose monitoring and / or visual reading
- Blood glucose monitors without special features unless required due to blindness;
- Lancets; lancing devices
- Alcohol swabs;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Diagnosis and Treatment of Autism and Other Developmental Disabilities

Coverage is provided for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability, the following medically necessary therapies as prescribed through a treatment plan and subject to any benefit limits reflected on the Schedule of Benefits are covered:

- occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
- physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
- speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits under the Rehabilitation Benefits Section of this Booklet-Certificate.

If a Covered Person's primary diagnosis is autism, and the Covered Person is under 21 years of age, in addition to coverage for therapy services described above, **Aetna** will also cover medically necessary behavioral interventions based upon principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan (s) must be in writing, signed by the treating physician, and must include:

- a diagnosis,
- proposed treatment, by type, frequency, and duration;
- the anticipated outcomes stated as goals; and
- the frequency by which the treatment plan will be updated.

Aetna may request additional information if necessary to determine the coverage under the plan. **Aetna** may require the submission of an updated treatment plan once every (6) months unless **Aetna** and the treating physician agree to more frequent updates.

If a Covered Person:

- is eligible for early intervention services through the New Jersey Early Intervention System;
- has been diagnosed with autism or other developmental disability; and
- receives physical therapy, occupational therapy, speech therapy, and applied behavior analysis or related structured behavior services.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

Diagnostic and Preoperative Testing:

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations:

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Laboratory and Radiological Services:

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Important Reminder:

Refer to the *Schedule of Benefits* for details about any **deductible**, **payment percentage** and maximum that may apply to outpatient diagnostic testing, and lab and radiological

Outpatient Preoperative Testing:

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations:

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder:

Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder:

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Elective Abortions

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Covered Person are a Covered Expense under this plan.

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam.

Benefits are covered and payable only as outlined in the Schedule of Benefits.

Injury or Care to Mouth, Teeth and Gums

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.

- 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.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).
- 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.

Infertility

Basic Infertility Expenses:

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 mIU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet*.

Comprehensive Infertility Services Benefits

- If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by **Aetna**, subject to all the exclusions and limitations of this *Booklet*:

- Ovulation induction with menotropins has a maximum benefit of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by **Aetna**.

- Intrauterine insemination has a maximum of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by **Aetna**.

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);

- Zygote intrafallopian transfer (ZIFT);

- Gamete intra-fallopian transfer (GIFT);

- Cryopreserved embryo transfers;

- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

ART services for procedures that are **covered expenses** under this *Booklet*.

Eligibility for ART Benefits

To be eligible for ART benefits under this *Booklet*, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;

- Be referred by your **physician** to Aetna's infertility case management unit;

- Obtain pre-authorization from Aetna's infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet*:

- Up to 4 cycles and subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by **Aetna** or any affiliated company of **Aetna**) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;

- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the *Schedule of Benefits* section while covered under an **Aetna** plan;

- Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and

- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this *Booklet*.

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet*:

- ART services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;

- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;

- Reversal of sterilization surgery;

- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);

- Home ovulation prediction kits;

- Drugs related to the treatment of non-covered benefits;

- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and

IVIG;

- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

Important Note:

Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

Orthotics

The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Physician Services.

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

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

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 negotiated fee or the Recognized Charge that is allowed for the primary procedures; 50% of the negotiated fee or the Recognized Charge will be allowed for each additional procedure performed through the same incision. 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 Usual and Reasonable Charge 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 Usual and Reasonable percentage allowed for that procedure; and

If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Recognized Charge allowance.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
    - An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
    - A breast implant after a mastectomy;
    - Ostomy supplies, urinary catheters and external urinary collection devices;
    - Speech generating device;
    - A cardiac pacemaker and pacemaker defibrillators; and
    - A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the *Exclusions* section.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when

    - the defect results in severe facial disfigurement, or

    - the defect results in significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

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

The mammoplasty coverage will include reimbursement for:

- reconstruction of the breast on which the mastectomy has been performed,

- surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- 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.

Transgender Reassignment (Sex Change) Surgery

Covered expenses include changes in connection with a **medically necessary** Transgender Reassignment Surgery per Aetna's Clinical Policy Bulletin which includes the medical necessary criteria.

Covered expenses include:

- Charges made by a **physician** for:

    - Performing the surgical procedure; and

    - Pre-operative and post-operative hospital and office visits.

- Charges made by a **hospital** for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the **hospital's semi-private rate** will not be covered unless a private room is ordered by your **physician** and **precertification** has been obtained.

- Charges made by a Skilled Nursing Facility for inpatient services and supplies. Daily room and board charges over the semi-private rate will not be covered.

- Charges made for the administration of anesthetics.

- Charges for outpatient diagnostic laboratory and x-rays.

- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self – donated blood after the surgery has been scheduled.

Limitations:

Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Important Reminder:

No payment will be made for any covered expenses under this benefit unless they have been precertified by Aetna.

Short-Term Rehabilitation Therapy Services;

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below: The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six-week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.

- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and

- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Any services unless provided in accordance with a specific treatment plan;

- Services for the treatment of delays in speech development, unless resulting from **illness, injury**, or congenital defect;

- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;

- Services provided by a **home health care agency**;

- Services not performed by a **physician** or under the direct supervision of a **physician**;

- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;

- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits:

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits:

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;

- The outpatient department of a **hospital**; or

- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

- Professional services;

- Total parenteral nutrition (TPN);

- Chemotherapy;

- Drug therapy (includes antibiotic and antivirals);

- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Spinal Manipulation

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment of conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Services that are considered maintenance care are not covered.

Sterilization procedures.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;

- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.

- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.

- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

- Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;

- Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

- Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay,** physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and

- Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders:

To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;

- Services that are covered under any other part of this plan;

- Services and supplies furnished to a donor when the recipient is not covered under this plan;

- Home infusion therapy after the transplant occurrence;

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;

- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;

- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Mental Disorders And Substance Abuse

Mental Disorders

Covered expenses include charges made for the treatment of **mental disorders** by **behavioral health providers**.

Important Note:

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Plan Exclusions* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following conditions:

- There is a written treatment plan supervised by a **physician** or licensed provider; and

- The Plan is for a condition that can favorably be changed

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting

Partial Confinement Treatment
Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Substance Abuse

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers.**

In addition to meeting all other conditions of coverage, the treatment must meet the following criteria:

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Temporomandibular Joint Syndrome

Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome.

Wigs

Charges associated with the purchase of a wig after Chemotherapy.

AETNA 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. This call must be made at least 7 days in advance of services being rendered or within 48 hours after a Medical Emergency.

Inpatient and emergency admissions and surgical procedures not certified or authorized by Cost Management Services may result in a reduction of benefits. The Covered Person's reduction will not be applied to the Calendar Year coinsurance, deductible or copayments where applicable. Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

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) Precertification of the Medical Necessity for the following non-emergency services before Medical and / or Surgical services are provided:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice** facility;
- Outpatient **hospice care**;
- **Stays** in a **Residential Treatment Facility** for treatment of mental disorders and substance abuse;
- **Partial Hospitalization Programs** for mental disorders and substance abuse;
- **Acupuncture**
- **Durable Medical Equipment (in excess of $500)**
- **Emergency Services**
- **Home health care**

- **Home Infusion Therapy**
- **Infertility Services**
- **MRI/Cat Scans**
- **Short Term Therapy: Cardiac Rehabilitation, Respiratory Therapy, Occupational, Physical and Speech Therapy, Radiation and Chemotherapy**
- **Transplant Services**
- **Private duty nursing** care;

Intensive Outpatient Programs for mental disorders and substance abuse;

- **Applied Behavioral Analysis**;
- **Neuropsychological testing**;
- **Outpatient detoxification**;
- **Psychiatric home care** services;
- **Psychological testing**.

(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 5 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.**

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If the Covered Person does not receive referred care, any covered services will be paid on an out-ot-network basis.

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 pre-certified, 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 mandatory 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.

As patterns of medical practice change, the specific procedures, which require a second opinion, also change. All Covered Persons can receive a list of surgeries for which a second and/or third opinion is required. Please contact the utilization review administrator for this list.

Before a Covered Person has a surgery performed that is on the list, the Covered Person must contact the utilization review administrator at the number 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.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered charges for this testing will be paid in accordance to the schedule of benefits shown, even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

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 case manager, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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 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.

Alcoholism Treatment Facility is a facility that primarily engages in providing Detoxification and Rehabilitation treatment of Alcoholism.

The Detoxification Facility is a health care facility licensed by the state in which it operates, as a Detoxification Facility for the treatment of Alcoholism.

A Residential Facility is a health care facility licensed, certified or approved by the state in which it operates, as a Residential Facility for the treatment of Alcoholism.

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.

Body Mass Index is a practical marker that is used to access the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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

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

Coinsuranc*e*. The percentage of charges that a Covered Person is required to pay for eligible charges and expenses under this Plan.

Copay or Copayment is the specific dollar amount or percentage required to be paid by you or on your behalf.

Cosmetic. Services or supplies that alter, improve or enhance appearance.

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

Covered Person is an Employee, Retiree 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.

Day Care Treatment. A partial confinement treatment program to provide treatment during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible. The part of a covered expense you must pay before the plan starts to pay benefits.

Detoxification. The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug -dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug; alcohol or drug-dependent factors or alcohol in combination with drugs as determined by a physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

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 Medical Condition means a recent and severe medical condition, including (but not limited to) severe pain which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Township of West Milford.

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 Claims Administrator must make an independent evaluation of the experimental/non-experimental 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 Claims Administrator will be guided by the following principles:

- A drug, device, procedure or treatment will be determined to be experimental if:
- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or
- It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or
- It is provided or performed in special settings for research purposes.

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.

Facility Charges are charges from an approved medical institution such as a Hospital, Residential Treatment Center, Detoxification Center, Ambulatory or Freestanding Surgical Center. These charges are generally paid under the Medical provisions of this Plan.

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

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's or Domestic Partner's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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 Care is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency is an organization that meets all of the following requirements:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
    - Skilled nursing services;
    - Medical social services; and
    - Psychological and dietary counseling.

- Provides, or arranges for, other services which include:
    - Physician services;
    - Physical and occupational therapy;
    - Part-time home health aide services which mainly consist of caring for terminally ill people; and
    - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
    - One physician;
    - One R.N.; and
    - One licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Plan is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility is a facility, or distinct part of one that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physician's other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

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 a condition of a presumably healthy covered person who is unable to conceive or produce conception.

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 lifesaving 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 30-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.

Maintenance Care means services and supplies that are given mainly to maintain, rather than improve a level of physical or mental function.

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

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

If the plan determines that a service is medically necessary under the plan and can be provided in a medically accepted setting providing a cost-effective alternative method of care, the plan reserves the right to provide benefits for such services when performed in the alternative setting.

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.

A mental disorder is an illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

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** with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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

Non-Covered Charges are charges for services and supplies which: (a) do not meet the definition of **Covered Charges,** (b) exceed any of the coverage limits shown in this Booklet; or (c) are specifically identified in this Booklet as **Non-Covered Charges**.

Occupational Injury or Occupational Illness is an injury or illness that arises out of any activity in connection with employment or self-employment whether or not on a full-time basis.

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.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

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 North Jersey Municipal Employee Benefits Fund Health Care Plan, Town of Dover, which is a benefits plan for certain Employees of Town of Dover 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.

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.

Preventive Care. Services or supplies that are not provided for the treatment of an Injury or Illness. It includes, but is not limited to; routine physical exams, including: related x-rays and lab tests, immunizations and vaccines; screening tests; well baby care and well adult care.

Primary Care Physician (PCP*)* is a network provider who is selected by a person and supervises, coordinates and provides initial care and basic medical services as a general or family care practitioner (or in some cases), an internist or a pediatrician.

Recognized Charge is a charge, which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

Rehabilitation Hospital is a facility that is primarily engaged in providing rehabilitation care and services on an inpatient basis. Rehabilitation care consists of the combined use of medical, social, educational and vocational services to enable patients disabled by Sickness or Injury to achieve the highest possible level of functional ability. Services are to be provided by or under the supervision of an organized staff of physicians. Continuous nursing services re to be provided under the supervision of a Registered Nurse.

Retired Employee is a former Active Employee of the Employer who retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required, if any.

Sickness is a person's illness, disease or Pregnancy (including complications).

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

- 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.

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

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

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- 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.

- 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.

Urgent Condition is a sudden illness; injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available

Usual and Customary Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Participating Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

AETNA PLAN EXCLUSIONS

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary.** Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section of this Booklet.

Note: All exclusions related to Dental are shown in the Dental Plan Section.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Ambulance services for transportation from a Hospital or other health care facility unless the Member is being transported to another health care facility for treatment of a medical condition which cannot be performed in the facility in which the patient is currently confined.

Behavioral Health Services*:*

- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet.

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.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges for a service or supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic Services. Care and treatment, and any related services or supplies provided for cosmetic reasons which are performed primarily to alter or improve any portion of the body.

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;

- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;

- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;

- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and

- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;

- Surgery to correct Gynecomastia;

- Breast augmentation;

- Otoplasty.

This exclusion will not apply if the care and treatment, services or supplies are provided for or performed for the:

- Repair of any deformities or defects of a bodily part resulting from an accidental injury; or

- Replacement of diseased tissue as a result of a sickness and/or which has been surgically removed; or

- Correction of an abnormal congenital defect or a condition that interferes with the bodily, but not psychological, function, or a developmental anomaly; or

- Reconstructive mammoplasty following Medically Necessary surgery.

Counseling Services. Treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

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

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentist**s, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;

- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:

  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;

  - by any law of a government;

  - for securing insurance, school admissions or professional or other licenses;

  - to travel;

  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and;

Any special medical reports not directly related to treatment except when provided as part of a covered service.
Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable or Recognized Charge.

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. Drugs, devices, care, treatment and procedures that is either Experimental/Investigational or not Medically Necessary.

Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting except as may be covered in the Schedule of Benefits. 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.

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 for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

Hearing.

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the *Summary of Benefits* section.

Home and mobility. Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;

- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and

- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

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.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;

- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;

- Procedures, services and supplies to reverse voluntary sterilization;

- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;

- Home ovulation prediction kits or home pregnancy tests; and

- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care of Chronic Conditions.

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

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

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.

Non-medically necessary services, including but not limited to, those treatments, services, and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

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. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Only Medically Necessary non-surgical charges for Morbid Obesity will be covered.

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 non- hospital adjustable beds.

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

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.

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.

Sex change: Except as provided under Transgender Reassignment (Sex Change) Surgery, coverage is excluded or any treatment, drug, service or supply related to changing sex or sexual characteristics, such as:

- Cosmetic procedures and surgeries; and
- Prosthetic devices

Sexual dysfunction/enhancement. Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

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

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

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

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;

- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

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

Vitamins and dietary supplements, except prenatal and children's vitamins requiring a Prescription.

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

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

UNITED HEALTHCARE MEDICAL PLANS

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 bargaining unit contracts, date of hire, or participant contributions.

Verification of Eligibility: Refer to the instructions on the ID card.

Call the number on the ID card 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 determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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 bargaining unit contracts, date of hire, or participant contributions

Note: Pre-authorization is required for the following services or reimbursement from the Plan may be reduced.

Durable Medical Equipment

Emergency Services

Home Health Care

Hospice Care

Hospitalizations

Reconstructive Procedures

Skilled Nursing Facility stays

Substance Abuse/Mental Disorder treatments

Surgical Procedures

Transplantations

The attending Physician does not have to obtain pre-authorization 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.

Please see the Cost Management section in this booklet for details.

The Plan is a plan that contains a Network Provider Organization.

Network name: United Healthcare Choice Plus

This network 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.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

UNITED HEALTHCARE – SCHEDULE OF BENEFITS

United Healthcare CHOICE PLUS 20 GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	$300
Per Family Unit	N/A	$600
The Calendar Year deductible is waived for the following Covered Charges: - Preventive Care up to an annual maximum of $150		
COPAYMENTS		
Hospital services	100%	80% after deductible
Office visits	$20 copay	80% after deductible
Outpatient services	100%	80% after deductible
Emergency room/Urgent Care	$100 copay waived if admitted	$100 copay waived if admitted
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	N/A	$2,000
Per Family Unit	N/A	$4,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which 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 out-of-pocket maximum and are never paid at 100%. Deductible(s) Copayments Amounts over UCR or Recognized Charge		
COVERED CHARGES		
Hospital Services – pre-notifification required		
Room and Board	100% coverage the semiprivate room rate	80% after deductible the semiprivate room rate
Intensive Care Unit	100% coverage	80% after deductible
Maternity Unit	100% coverage the semiprivate room rate	80% after deductible the semiprivate room rate
Skilled Nursing Facility Calendar Year maximum	100% coverage facility's semiprivate room rate N/A	80% after deductible facility's semiprivate room rate 240 days and 35 physician visits
Pre-Admission Testing	100% coverage	80% after deductible
Diagnostic Xray Lab Outpatient	100% coverage	80% after deductible
Physician Services		
Inpatient visits	100% coverage	80% after deductible
Office visits	$20 copay	80% after deductible
After Hour / Home visits	$25 copay	80% after deductible
Surgery	100% coverage	80% after deductible
Allergy testing/serum/injections	$20 copay	80% after deductible
Specialists	$25 copay	80% after deductible
Home Health Care	100% coverage	80% after deductible

United Healthcare CHOICE PLUS 20 GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Private Duty Nursing Outpatient	100% coverage	80% after deductible
Hospice Care	100% coverage	80% after deductible
Ambulance Service	100% coverage	80% after deductible
Jaw Joint/TMJ	Refer to physician services and surgical benefits	Refer to physician services and surgical benefits
Chemotherapy - Outpatient	100% coverage	80% after deductible
Radiation Therapy - Outpatient	100% coverage	80% after deductible
Infusion Therapy - Outpatient	100% coverage	80% after deductible
Wig After Chemotherapy	100% coverage	80% after deductible
Benefit Maximum	$500 every 24-month period – Combined In and Out of Network	
Cardiac Rehabilitation Therapy	$20 copay 60 visits per 60 consecutive day period per illness or injury	80% after deductible Based on medical review
Occupational Therapy Calendar Year maximum	$20 copay 60 visits per 60 consecutive day period per illness or injury	80% after deductible based on medical review
Speech Therapy Calendar Year maximum	$20 copay 60 visits for 60 consecutive day period per illness or injury	80% after deductible based on medical review
Physical Therapy Calendar Year maximum	$20 copay 60 visits for 60 consecutive day period per illness or injury	80% after deductible based on medical review
Durable Medical Equipment requires preauthorization over $1500	100% coverage	80% after deductible
Prosthetics requires preauthorization	100% coverage	80% after deductible
Orthotics **requires preauthorization**	100% coverage	80% after deductible
Spinal Manipulation/Chiropractic Calendar Year maximum	$25 copay 40 visits	80% after deductible 20 visits
Mental Disorders		
Inpatient	100% coverage	80% after deductible
Partial Hospitalization	2 partial days for 1 inpatient days	2 partial days for 1 inpatient days
Outpatient	$25 copay	80% after deductible
Alcohol and Substance Abuse		
Inpatient Detoxification Rehabilitation	100%	80% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day

United Healthcare CHOICE PLUS 20 GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Outpatient	$25 copay	80% after deductible
Preventive Care		
Routine Well Adult Care Calendar Year maximum	$20 copay 1 visit	100% coverage $150 maximum
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for mammogram Age 35 through 39 . . . . . one baseline exam Ages 40 and over . . . . . annually		
Routine Well Child Care Calendar Year maximum	$20 copay N/A	100% coverage $150 maximum
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations through age 12.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	80% after deductible
Organ Transplants	100% coverage	80% after deductible
Prescription Drugs	Deductible waived; 80% coverage until annual out-of-network maximum out-of-pocket is satisfied, then coverage at 100%	
Infertility Benefits (IVF GIFT ZIFT)	100% coverage	80% after deductible
Lifetime maximum	3 attempts – Combined In and Out of Network Includes: care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility.	

UNITEDHEALTHCARE CHOICE PLUS 25 NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	$500
Per Family Unit	N/A	$1000
Inpatient Confinement Deductible	$300 per confinement	$300 per confinement
The Calendar Year deductible is waived for the following Covered Charges: - Preventive Care up to an annual maximum of $150		
COPAYMENTS		
Hospital services	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Office visits	$25 copay	80% after deductible
Outpatient Surgery, Diagnostic and Therapeutic Services	100% coverage	80% after deductible
Emergency room	$100 copay waived if admitted	$100 copay waived if admitted
Urgent Care	$25 copay	80% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$2000	$2,000
Per Family Unit	$4000	$4,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which 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 out-of-pocket maximum and are never paid at 100%. Deductible(s) Copayments Amounts over UCR or Recognized Charge		
COVERED CHARGES		
Hospital Services – pre-notifification required		
Room and Board Semiprivate Room Rate	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Intensive Care Unit	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Maternity Unit	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Skilled Nursing Facility Semiprivate room rate Calendar Year maximum	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible 240 days and 35 physician visits
Pre-Admission Testing	100% coverage	80% after deductible
Diagnostic Xray Lab Outpatient	100% coverage	80% after deductible
Physician Services		
Inpatient visits	100% coverage	80% after deductible
Office visits	$25 copay	80% after deductible

UNITEDHEALTHCARE CHOICE PLUS 25 NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
After Hour / Home visits	$25 copay	80% after deductible
Surgery	100% coverage	80% after deductible
Allergy testing/serum/injections	$25 copay	80% after deductible
Specialists	$25 copay	80% after deductible
Home Health Care	100% coverage	80% after deductible
Private Duty Nursing Outpatient	100% coverage	80% after deductible
Hospice Care	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Ambulance Service Emergency Services *****_No coverage for non-emergency use_	100% coverage	100% coverage
Jaw Joint/TMJ	Refer to physician services and surgical benefits	Refer to physician services and surgical benefits
Chemotherapy - Outpatient	100% coverage	80% after deductible
Radiation Therapy - Outpatient	100% coverage	80% after deductible
Infusion Therapy - Outpatient	100% coverage	80% after deductible
Wig After Chemotherapy	100% coverage	80% after deductible
Benefit Maximum	$500 every 24-month period – Combined In and Out of Network	
Cardiac Rehabilitation Therapy	$25 copay 60 visits per 60 consecutive day period per illness or injury	80% after deductible Based on medical review
Occupational Therapy Calendar Year maximum	$25 copay 60 visits per 60 consecutive day period per illness or injury	80% after deductible based on medical review
Speech Therapy Calendar Year maximum	$25 copay 60 visits for 60 consecutive day period per illness or injury	80% after deductible based on medical review
Physical Therapy Calendar Year maximum	$25 copay 60 visits for 60 consecutive day period per illness or injury	80% after deductible based on medical review
Durable Medical Equipment requires preauthorization over $1500	100% coverage	80% after deductible
Prosthetics requires preauthorization	100% coverage	80% after deductible
Orthotics requires preauthorization	100% coverage	80% after deductible
Spinal Manipulation/Chiropractic Calendar Year maximum	$25 copay 40 visits	80% after deductible 20 visits
Mental Disorders		
Inpatient	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible

UNITEDHEALTHCARE CHOICE PLUS 25 NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Partial Hospitalization	2 partial days for 1 inpatient days	2 partial days for 1 inpatient days
Outpatient	$25 copay	80% after deductible
Alcohol and Substance Abuse		
Inpatient Detoxification Rehabilitation	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Outpatient	$25 copay	80% after deductible
Preventive Care		
Routine Well Adult Care Calendar Year maximum	100% coverage 1 visit	Not covered
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for mammogram Age 35 through 39 . . . . . one baseline exam Ages 40 and over . . . . . annually		
Routine Well Child Care Calendar Year maximum	100% coverage	Not covered
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations through age 12.		
***Additional Preventative Care services shall be provided as required by the Affordable Care Act and provided by a Network Physician. Visit www.HealthCare.gov for a complete listing of covered services.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	80% after deductible
Organ Transplants	100% coverage after $300 per confinement deductible	80% after $300 per confinement deductible
Infertility Inpatient - $300 per confinement deductible appllies **IVF, GIFT, ZIFT**	100% coverage	80% after deductible
Lifetime Maximum	3 attempts – Combined In and Out of Network includes: care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility.	
Prescription Drugs	Deductible waived – 80% coverage for generic drugs, 70% coverage for Brand name drugs until the annual out of network maximum out of pocket has been satisfied, then coverage at 100%.	

UNITEDHEALTHCARE PREFERRED PLAN CHOICE PLUS NETWORK NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Covered expenses accumulate toward both the Network and Non-Network Deductible.		
Per Covered Person	$500	$500
Per Family Unit	$1000	$1000
COPAYMENTS		
Hospital services	80% after deductible	60% after deductible
Physician visits	$20 copay	60% after deductible
Specialist	$40 copay	60% after deductible
Emergency room ***Non-Emergency care in the Emergency Room is not covered***	$100.00 copay; then 80% Deductible waived Copay waived if Admitted	$100.00 copay; then 80% Deductible waived Copay waived if Admitted
Urgent Care Facility	$40 copay	60% after deductible
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Covered Network Expenses applied towards the Network Out of Pocket Maximum will also apply towards the Non-Network Out of Pocket Maximum		
Per Covered Person	$2000	$4000
Per Family Unit	$4000	$8000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which 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 out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Copayments Amounts in excess of the Recognized Charge		
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible semiprivate room rate	60% after deductible semiprivate room rate
Intensive Care Unit	80% after deductible	60 % after deductible
Maternity Unit	80% after deductible semiprivate room rate	60% after deductible semiprivate room rate
Skilled Nursing Facility Calendar Year Maximum 240 Days	80% after deductible facility's semiprivate room rate	60% after deductible facility's semiprivate room rate
Hospice Facility	80% after deductible	60% after deductible
Private Duty Nursing **Out Patient** Precertification is required	80% after deductible	60% after deductible
Diagnostic Testing Outpatient XRay and Lab Test Complex Imaging Services	80% after deductible	60% after deductible
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	$20 copay	60% after deductible
After Hour / Home visits	$20 copay	60% after deductible

UNITEDHEALTHCARE PREFERRED PLAN CHOICE PLUS NETWORK NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Specialists visits	$40 copay	60% after deductible
Surgery / Anesthesia	80% after deductible	60% after deductible
Allergy testing and treatment	$40 copay	60% after deductible
Home Health Care Calendar year maximum 120 visits	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
Ambulance Ground, Water or Air	80% after deductible	60% after deductible
Wig After Chemotherapy Maximum per 24 months - $500	80% coverage Deductible does not apply	60% after deductible
Occupational Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	60% after deductible
Physical Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	60% after deductible
Speech Therapy Subject to Medical Review Limited to 30 visits per condition per calendar year	$40 copay	80% after deductible
Chemotherapy - Outpatient	80% after deductible	60% after deductible
Radiation Therapy - Outpatient	80% after deductible	60% after deductible
Infusion Therapy - Outpatient	80% after deductible	60% after deductible
Dialysis - Outpatient	80% after deductible	60% after deductible
Durable Medical Equipment Requires precertification over $500	80% after deductible	60% after deductible
Prosthetics Requires precertification over $500	80% after deductible	60% after deductible
Orthotics Requires precertification over $500	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic Subject to Medical Review 30 visits per calendar year max	$40 copay	60% after deductible
Mental Disorders		
Inpatient Residential Treatment Facility Outpatient	80% after deductible 80% after deductible $40 copay	60% after deductible 60% after deductible 60% after deductible
Substance Abuse		
Inpatient Residential Treatment Facility Outpatient Outpatient Detoxification	80% after deductible 80% after deductible $40 copay $40 copay	60% after deductible 60% after deductible 60% after deductible 60% after deductible
Partial Hospitalization	2 partial days for 1 inpatient day	2 partial days for 1 inpatient day
Preventive Care		

UNITEDHEALTHCARE PREFERRED PLAN CHOICE PLUS NETWORK NON-GRANDFATHERED	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine Well Adult Care 1 visit every 12 months 18 +	100% coverage	Covered up to $150 Preventative Care Max
Routine Gynecological Exam 1 visit per Calendar Year	100% coverage	Covered up to $150 Preventative Care Max
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, hearing tests, vision tests and immunizations/flu shots.		
Frequency limits for Mammogram Ages 35 through 39 . . . one baseline exam Ages 40 and over. . . . . .annually (includes 3D Mammogram)		
Frequency limits for Prostate Screening Age 40 and over…….one annual Prostrate screening		
Routine Eye Exam Benefit Maximum	100% coverage one exam every 24 months	Not Covered
Routine Well Newborn Care Inpatient	100% coverage	Covered up to $150 Preventative Care Max
Routine Well Child Care	100% coverage	Covered up to $150 Preventative Care Max
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests, vision tests and immunizations.		
***Additional Preventative Care services shall be provided as required by the Affordable Care Act and provided by a Network Physician. Visit www.HealthCare.gov for a complete listing of covered services.		
Hearing Aids for children 15 years of age or younger. Coverage is provided to a maximum of $1000 per hearing aid for each hearing impaired ear every 24 months	100% coverage	60% after deductible
Prescription Drug Benefit	20% coinsurance card after deductible	20% coinsurance card after deductible
Prenatal Care		
First OB visit Subsequent Prenatal Visits	$20 copay 100% coverage	60% after deductible 60% after deductible
Organ Transplants	Payable in accordance with the type of expense incurred and the place where services provided.	60% after deductible
Infertility Services Office Visit Out-Patient Services Advanced Reproductive Technology Maximum of 4 egg retrievals per lifetime Lifetime Limit - $15,000	 $40 copay 80% after deductible	 60% after deductible 60% after deductible
Includes: care, supplies and services for the diagnosis of infertility and treatment for underlying medical cause of infertility.		

UNITED HEALTHCARE MEDICAL BENEFITS

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.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. This amount will not accrue toward the 100% maximum out-of-pocket payment.

If a Covered Person was covered under this Plan on the day this Plan may begin under new claims administration, any charges for covered medical expenses that were applied to the deductible may be applied toward the satisfaction of this Plan's Medical deductible for the initial period.

Family Unit Limit.

When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible Three-Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Deductible for a Common Accident. When 2 or more Covered Persons in a Family Unit are injured in the same accident these persons do not need to meet separate deductibles for treatment of injuries incurred in this accident. Only 1 deductible for the Calendar Year in which the accident occurred will be required for them as a unit for only those expenses arising from the accident.

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% (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.

UNITED HEALTHCARE COVERED CHARGES

Covered charges are the Usual and Reasonable Charges or contracted fees 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. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

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

Coverage of Pregnancy. The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. Charges incurred for **Pregnancy** of Dependents are covered as any other Illness.

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:

- the patient is confined as a bed patient in the facility; and
- the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- 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:

- If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. 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;

- If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge 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 Usual and Reasonable percentage allowed for that procedure; and

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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:

- **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.

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. The Home Health Care Plan must be in writing and provided by the Attending Physician before care begins and be reviewed by the Attending Physician at least once every 60 days.

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.

When home health care can take the place of inpatient care, this Plan covers such care provided to the Covered Person under a written Home Health Care Plan. Medically Necessary services or supplies, when eligible under this provision are:

- routine nursing care (provided by or under the supervision of a Registered Nurse;

- physical therapy;

- occupational therapy;

- medical social work;

- nutrition services;

- speech therapy;

- home health aide services;

- medical appliances and durable medical equipment, drugs and medications, laboratory services and special meals; and

- any diagnostic or therapeutic service, including service performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, provided such service would have been covered under this Plan if performed as inpatient Hospital services.

Hospice Care Services and Supplies. Charges for hospice care services and supplies are covered only under Case Management and 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:

Charges incurred for an elective **abortion.**

Acupuncture services and supplies are covered when:

- the Acupuncture is performed for anesthetic or therapeutic purposes by a Practitioner; and
- the services are determined to be medically necessary.

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 a longer trip was Medically Necessary.

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

Diagnosis and Treatment of **Autism and Other Developmental Disabilities**

Coverage is provided for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability, the following medically necessary therapies as prescribed through a treatment plan and subject to any benefit limits reflected on the Schedule of Benefits are covered.

- occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
- physical therapy where physical therapy refers to treatments to develop a Covered Person's physical function; and
- physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
- speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits under the Rehabilitation Benefits Section of this Booklet-Certificate.

If a Covered Person's primary diagnosis is autism, and the Covered Person is under 21 years of age, in addition to coverage for therapy services described above, UnitedHealthcare will also cover medically necessary behavioral interventions based upon principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan (s) must be in writing, signed by the treating physician, and must include:

- a diagnosis,
- proposed treatment, by type, frequency, and duration;
- the anticipated outcomes stated as goals; and
- the frequency by which the treatment plan will be updated.

UnitedHealthcare may request additional information if necessary to determine the coverage under the plan. UnitedHealthcare may require the submission of an updated treatment plan once every (6) months unless UnitedHealthcare and the treating physician agree to more frequent updates.

If a Covered Person:

- is eligible for early intervention services through the New Jersey Early Intervention System;
- has been diagnosed with autism or other developmental disability; and
- receives physical therapy, occupational therapy, speech therapy, and applied behavior analysis or related structured behavior services.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

Charges incurred for **breast prosthesis** are covered when provided by and billed for by a Physician following recommended breast surgery.

Cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

- under the supervision of a Physician;
- in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
- initiated within 12 weeks after other treatment for the medical condition ends; and
- 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.

Charges incurred for any educational training, test, test item or medical supply pertaining to the monitoring, maintenance and/or treatment of a **diabetic condition.**

This Plan will pay the cost of **dialysis** when the services are provided and billed by a Hospital, Freestanding Dialysis Center or Home Health Agency. The facility must make arrangements for training, equipment, rental and supplies on behalf of the Covered Person.

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.

Durable Medical Equipment is:

- primarily and customarily used for medical purposes and is not generally useful in the absence of Sickness or Injury;
- can effectively be used in a non-medical facility (home);
- be expected to make a significant contribution to the treatment of Sickness or Injury;
- is used solely for the care and treatment of the Covered Person/patient; and
- the cost of the equipment is proportionate to the therapeutic benefits which can be derived from the use of the equipment.

Rental or purchase of items (such as air conditioning, exercise equipment, saunas and air humidifiers do not meet the definition of durable medical equipment.

Charges incurred for an open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; the removal of nail roots; or the treatment of corns, calluses or toenails, if the Covered Person has a metabolic or peripheral vascular disease) will be considered eligible. Non-surgical treatment or routine **foot care** is not covered under this Plan.

Charges incurred for scalp **hair prostheses** prescribed or authorized by a Physician but only if they are needed for hair loss resulting from treatment of 1) disease by radiation or chemicals; 2) alopecia universalis (totalis); or 3) alopecia areata. The maximum amount that will be paid is outline in the Schedule of Benefits.

Charges incurred for the **screening for lead poisoning** and related follow-up treatment, including development assessment and all **childhood immunizations** that have been recommended by the U.S. Department of Public Health Services will be covered under this Plan. The Plan's deductible will be waived for these services.

Care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of **infertility**.

The following services are **not** covered:

- Reversal of voluntary sterilization
- Medical services given to a surrogate for the purposes of childbearing if the surrogate is not a covered person
- The cryopreservation and storage of sperm, eggs and embryos
- Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist
- Non-medical costs of an egg or sperm donor
- Ovulation kits and sperm testing kits and supplies

Charges related to the expenses incurred in the therapeutic treatment of **Inherited Metabolic Diseases**, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be Medically Necessary by the Covered Person's Physician.

Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**. The care and treatment may include diagnostic testing and evaluation, Physician office visits, physical therapy and a non- orthodontic removable appliance. A complete treatment plan for such services requires prior evaluation and authorization. Services which are orthodontic or orthognathic in nature are not eligible.

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

Charges incurred for a routine **mammography** will be covered as described in the Schedule of Benefits.

Medical and surgical charges incurred with respect to a **mastectomy** will include the following should a Covered Person elect reconstruction in connection with such a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of a mastectomy; including lymphedemas; in a manner determined in consultation with the Attending Physician and the Covered Person/patient.

Treatment of **Mental Disorders and Substance Abuse**. 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 and follow-up care due to accidental Injury to sound natural teeth within 12 months of injury. Dental prosthesis replacing accidentally injured teeth is included. A treatment plan for services must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time may be extended.
- 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.
- Hospital and general anesthesia services provided to a severely disabled Covered Person or a Covered child age 5 or under for dental services.
- A Medical Condition eligible under this Plan, which requires Hospital and general anesthesia for dental services rendered by a Dentist.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of impacted teeth.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).
- 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. Organ and tissue transplants are covered except those that are classified as "Experimental and/or Investigations". Pre-certification and prior authorization is required in order for such services to be covered. 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. If the organ donor is a Covered Person and the recipient is not, this Plan will not cover charges incurred for obtaining the donor organ or tissue from the Covered Person. 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, 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.

Charges incurred for a routine **prostate screening** and examination are covered as described in the Schedule of Benefits.

Charges incurred for the initial purchase, fitting, repair and replacement of fitted **prosthetic devices,** which replace body parts as described in the Schedule of Benefits.

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.

Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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:

- reconstruction of the breast on which a mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- 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.

Transgender Reassignment **(Sex Change)** Surgery:

Covered expenses include changes in connection with a **medically necessary** Transgender Reassignment Surgery per Aetna's Clinical Policy Bulletin which includes the medical necessary criteria.

Covered expenses include:

- Charges made by a **physician** for:
  - Performing the surgical procedure; and
  - Pre-operative and post-operative hospital and office visits.
- Charges made by a **hospital** for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the **hospital's semi-private rate** will not be covered unless a private room is ordered by your **physician** and **precertification** has been obtained.
- Charges made by a Skilled Nursing Facility for inpatient services and supplies. Daily room and board charges over the semi-private rate will not be covered.
- Charges made for the administration of anesthetics.
- Charges for outpatient diagnostic laboratory and x-rays.
- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self – donated blood after the surgery has been scheduled.

Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic and not covered.

Charges incurred for **smoking cessation** programs are covered when provided and prescribed by a Physician and are Medically Necessary due to a severe acute lung Sickness, such as emphysema or asthma.

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.

- Coverage will be provided for the treatment of delays in speech development resulting from disease, injury, congenital defects or are related to the diagnosis of Autism and Pervasive Development Disorder (PDD).

Charges incurred for **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. will be considered eligible under this Plan as described in the Schedule of Benefits when Medically Necessary and not considered maintenance.

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

Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome** as described in the Schedule of Benefits. A complete treatment plan for such services requires prior evaluation. Services that are orthodontic or orthognathic in nature are not eligible.

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 Usual and Reasonable Charges for nursery care for the first 3 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).

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 after chemotherapy**.

This Plan provides benefits for covered charges for the treatment of **Wilm's tumor**. Charges are treated the same way as any other covered charges for any other Sickness. Treatment can include, but is not limited to autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. This Plan provides benefits for this treatment even if it is deemed experimental or investigational, and based on all of the provisions of this Plan.

Diagnostic **x-rays**.

UNITED HEALTHCARE - COST MANAGEMENT SERVICES

Cost Management Services Phone Number

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

The patient or family member should call this number to receive certification of certain Cost Management Services. This call must be made seven business days in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

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:

Note: Pre-authorization of the Medical Necessity for the following non-emergency services before Medical and / or Surgical services are provided.

Durable Medical Equipment

Emergency Services

Home Health Care

Hospice Care

Hospitalizations

Prosthetic / Orthotic Devices

Reconstructive Procedures

Skilled Nursing Facility stays

Substance Abuse/Mental Disorder treatments

Surgical Procedures

Transplantations

- Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- Authorization 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 authorized, 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 authorized before incurring charges.

The attending Physician does not have to obtain pre-authorization 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.

Pre-authorization. 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, authorize the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

For referred and in-network services, the utilization review program is set in motion by a telephone call from the attending physician.

For non-referred and out-of-network services, the utilization review program is set in motion by a telephone call from 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
- The name, Social Security 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 diagnosis and/or type of surgery
- 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 Utilization Review procedures may reduce reimbursement received from the Plan.

If the Covered Person does not receive authorization, as required, there may be a reduction of benefits. The eligible services will be payable at plan's coinsurance levels; however, the out of pocket coinsurance will not be applied to the Calendar Year coinsurance out of pocket maximum.

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 the original pre-authorization, the attending Physician must request the additional services or days.

When discharge is indicated, discharge planning plays an important part in managing care. The timing of moving the Covered Person to the appropriate setting and giving the Covered Person informational guidance will allow the Covered Person to have a smooth transition after leaving an acute care facility.

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 mandatory 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.

As patterns of medical practice change, the specific procedures, which require a second opinion, also change. All Covered Persons can receive a list of surgeries for which a second and/or third opinion is required. Please contact the utilization review administrator for this list.

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

- Board Certified Specialists in the area in which the operation is concerned; and
- not financially associated with either the surgeon originally recommending surgery or, in the case of a third opinion, with each other.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- performed on an outpatient basis within seven days before a Hospital confinement;
- related to the condition which causes the confinement; and
- performed in place of tests while Hospital confined.

Covered charges for this testing will be paid in accordance to the schedule of benefits shown, even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

HIGH RISK MATERNITY REVIEW PROGRAM

The High Risk Maternity Review Program focuses on an early identification and intervention of potential high-risk pregnancies and subsequent management of services needed to protect the health of both the mother and child.

During the first trimester, High Risk Maternity Review begins with a call from the Covered Person or Attending Physician to the Utilization Review Administrator for an initial screening. A risk assessment is taken and the treatment plan is reviewed. Following this assessment, an evaluation of all clinical history data is made. If a high-risk situation is identified the case management process is initiated.

A Final Screening will be conducted after the birth to address any questions the Covered Person may have and determine if any further treatment is necessary.

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 case manager, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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.

UNITED HEALTHCARE DEFINED TERMS

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

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.

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

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

Cosmetic Dentistry means dentally unnecessary procedures.

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

Covered Person is an Employee, Retiree 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.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

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.

Employee means a person who is a Full-Time Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Township of West Milford.

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 and dental community or government oversight agencies at the time services were rendered.

The claims administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The claims 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 claims administrator will be guided by the following principles:

- 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

- 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

- 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

- 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 or Retiree and the family members who are covered as Dependents under the Plan.

Full-Time 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.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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.

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 31-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.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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 sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental 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 and dental 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 claims 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.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

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, Doctor of Dental Surgery (D.D.S.), 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 North Jersey Municipal Employee Benefits Fund Township of West Milford, which is a benefits plan for certain Employees of Township of West Milford and is described in this document.

Plan Participant is any Employee, Retiree 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.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer.

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

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

- 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.

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

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

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of Mental Disorders.

- 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. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, 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.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The claims administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

UNITED HEALTHCARE – PLAN EXCLUSIONS

If the Plan Document does NOT list or describe a service or supply or specifically exclude the service or supply, the service or supply is NOT necessarily covered and may NOT be eligible under the Plan of Benefits.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Ambulance services for transportation from a Hospital or other health care facility unless the member is being transported to another health care facility for treatment of a medical condition which cannot be performed in the facility in which the patient is currently confined.

Blood or **blood plasma,** which has been donated or replaced.

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.

Cosmetic Services. Care and treatment, and any related services or supplies provided for cosmetic reasons, which are performed primarily to alter or improve any portion of the body. This exclusion will not apply if the care and treatment, services or supplies are provided for or performed for the:

- Repair of any deformities or defects of a bodily part resulting from an accidental injury; or
- Replacement of diseased tissue as a result of a sickness and/or which has been surgically removed or:
- Correction of an abnormal congenital defect or a condition that interferes with the bodily, but not psychological, function, or a developmental anomaly; or
- Reconstructive mammoplasty following Medically Necessary surgery.

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

Dental care or treatment. Charges for Physician services or x-ray examination for a **mouth condition.** "Mouth condition" means only a condition involving 1 or more teeth, the tissue or structure around them or the alveolar process of the gums. This exclusion applies even if a condition requiring any of these services involve a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Syndrome (TMJ) or malocclusion involving joints or muscles by the methods including, but not limited to, crowning, wiring, or repositioning teeth. However, benefits may be provided under the criteria set forth under covered services when Medically Necessary.

Educational or vocational testing. Services for educational or vocational testing or training.

Charges for services involving **equipment** or facilities used when the purchase, rental or construction of them has not been approved in compliance with applicable state laws and regulations.

Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary or Recognized Charge or pre-negotiated contracted rate, whichever applies. The pre-negotiated contracted rate is the fee Network Providers agreed to accept for services rendered. If a charge for any service or supply is higher than the usual or recognized charge, a Participant is responsible for the difference between the usual or recognized charge and the actual charge. If a charge for any service or supply is higher than the pre-negotiated contracted charge, a participant is not responsible for an amount over the pre-negotiated contracted rate.

Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy 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. Also, routine eye examinations, other than outlined in the Schedule of Benefits, including refractions, lenses for the eyes and exams for their fitting. 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.

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 does not apply to Medicaid or when otherwise prohibited by law.

Governmental/Military Facility. Charges incurred during confinement in a Governmental Hospital for service related treatment.

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 for wigs after chemotherapy up to the limit as shown in the Schedule of Benefits.

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

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.

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

Medicare. Charges that should have been paid by Medicare if Medicare coverage had been in effect.

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 weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Surgical treatment charges that are Medically Necessary for Morbid Obesity will be covered under the criteria of the Plan's guidelines.

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 non-hospital adjustable beds.

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

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.

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.

Sex change: Except as provided under Transgender Reassignment (Sex Change) Surgery, coverage is excluded or any treatment, drug, service or supply related to changing sex or sexual characteristics, such as:

- Cosmetic procedures and surgeries; and
- Prosthetic devices

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and

- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

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

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

Surrogate parenting. Charges for the expenses of surrogate parenting.

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.

Vitamins. Charges incurred for vitamins and dietary supplements.

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

PRESCRIPTION DRUG BENEFITS

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 bargaining unit contracts, date of hire, or participant contributions.

If the Plan Document does NOT list or describe a service or supply of specifically exclude the service or supply, the service or supply is NOT necessarily covered and may NOT be eligible under the Plan of Benefits.

This benefit applies when covered charges are incurred by a person while covered under this Plan.

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the claims administrator and prescription benefits manager of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge as shown in the schedule of benefits.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, mail order pharmacy is able to offer Covered Persons savings on their prescriptions.

Accredo Specialty Pharmacy (Mandatory for Specialty Medications)

Specialty medications treat chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Although the incidences of these and other serious diseases are being diagnosed more commonly, the medicines needed to treat such conditions are far from common.

Accredo defines specialty medications as injectable and non-injectable drugs typically having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administrative requirements
- Cost in excess of $500 for a 30-day supply

Covered Prescription Drugs

- All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under the Plan.

- Insulin and other Diabetic supplies when prescribed by a Physician.

Limits to the Pharmacy Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug Charge. The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a Physician

- Refills up to one year from the date of order by a Physician

- Dosage and quantity as recommended by the FDA

- Prior Authorization may be required for certain drugs and / or drug classification(s)

Prior Authorization

Prior authorization is a review process to determine the appropriateness of a prescribed drug for the illness/injury within FDA guidelines and clinical efficacy. Specific drugs and drug classification are reviewed to determine if the plan requirements are met. The provider needs to contact Express – Scripts to determine if the drug will be covered before you go to your pharmacy to have the prescription filled.

Step Therapy

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost effective, clinical efficacy and safest methods then progressing to other more costly therapies if medically necessary through an authorization process. Step Therapy is designed especially for participants who take prescription drugs regularly to treat ongoing medical conditions, such as arthritis and high blood pressure. Step Therapy classifies medications into two categories and is designed to ensure that participants receive their medications with efficacy, safety and cost in mind.

Step 1 medications: These are the medications recommended the patient take first and have been proven safe and effective.

Step 2 medications: These are medications, which are recommended only if a Step 1 medication does not provide the clinical results for the participant.

Drug Quantity Management

Drug Quantity Management (DQM) is a program designed to make the use of prescription drugs safe. It provides you with medications you need for your good health and the health of your family, while making sure you receive them in the amount – or quantity – considered safe.

Certain medications are included in this program. For instance, the program could provide a maximum of 30 pills for a medication you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S. Food & Drug Administration (FDA). Prescription drugs may have limits for safety reasons, clinical guidelines and prescribing patterns, or potential for inappropriate use.

If your medication is available in different strengths, sometimes you could take one dose of a higher strength instead of two or more of a lower strength; which helps maintain compliance of dosage.

To determine if a medication is considered a specialty medication, members can either:

- Call 1-866-848-9870
- Search the Internet at www.express-scripts.com for a complete listing of specialty medications

Locating a Participating Pharmacy

To locate a participating pharmacy – members can either:

- Call 1-800-467-2006
- Search the Internet at www.express-scripts.com

By using either method to search for a pharmacy, you can obtain a listing of pharmacies in your area that participate with Express Scripts.

PRESCRIPTION DRUG - DEFINED TERMS

Brand Drug means a prescription drug product that is not a Generic Drug.

Copayment means that portion of the charge for each Covered Drug dispensed to the Member that is the responsibility of the Member (e.g., copayment, coinsurance and/or deductible) as indicated on the Set-Up Forms.

Covered Drug(s) means those prescription drugs, supplies, Specialty Products (if applicable), and other items that are covered under the Plan, each as indicated on the Set-Up Forms.

Accredo means Accredo, Inc. or another pharmacy wholly-owned or operated by ESI or its wholly-owned subsidiaries that primarily dispenses Specialty Products. For purposes of this Agreement, Accredo is not considered a Mail Service Pharmacy.

Formulary means the list of FDA-approved prescription drugs and supplies developed by ESI's Pharmacy and Therapeutics Committee and/or customized by Sponsor, which is selected and adopted by Sponsor.

Generic Drug means a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

ID Card means ESI's standard single purpose (NCPDP format) printed identification card containing the applicable ESI logo or other mutually acceptable method of identifying ESI as the provider of pharmacy benefit services.

Mail Service Pharmacy means a duly licensed pharmacy operated by ESI or its subsidiaries, other than Accredo, where prescriptions are filled and delivered to Members via mail delivery service.

Member means each person whose Sponsor determines is eligible to receive prescription drug benefits as indicated in the Eligibility Files.

Participating Pharmacy means any licensed retail pharmacy with which ESI has executed an agreement to provide Covered Drugs to Members.

Plan means Sponsor's welfare benefit plan(s) that contains a prescription drug benefit.

Prescription Drug Claim means a Member Submitted Claim or claim for payment submitted to ESI by a Pharmacy as a result of dispensing Covered Drugs to a Member.

Prior Authorization means the process of obtaining authorization for prescription plan coverage for a defined list of prescription drugs.

Protected Health Information or "PHI" has the meaning ascribed to it under HIPAA.

Usual and Customary Price or "U&C" means the retail price charged by a Participating Pharmacy for the particular drug in a cash transaction on the date the drug is dispensed as reported to ESI by the Participating Pharmacy.

PRESCRIPTION DRUG EXCLUSIONS

This benefit will not cover a charge for any of the following:

Administration. Any charge for the administration of a covered Prescription Drug.

Appetite suppressants. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

Blood or Blood Plasma.

Consumed on premises. Any drug or medicine that is consumed or administered at the place where it is dispensed.

Cosmetic. Any drugs used for cosmetic purposes (such as Retin A, Renova, Accutane, treatments for hair loss or growth, etc).

Devices. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Experimental. Experimental drugs and medicines, even though a charge is made to the Covered Person.

FDA. Any drug not approved by the Food and Drug Administration.

Immunization agents. Immunization agents or biological sera.

Inpatient medication. A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

Investigational. A drug or medicine labeled: "Caution - limited by federal law to investigational use".

Medical exclusions. A charge excluded under Medical Plan Exclusions.

Needles and Syringes. A charge for hypodermic syringes and / or needles directing administration by prescription drug, other than insulin.

No charge. A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

Non-legend drugs. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

No prescription. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

Over the Counter Medication. A charge for over the counter medication even if a physician prescribed such medication.

Performance enhancement medications such as those used to enhance athletic performance, or lifestyle enhancement drugs or supplies.

Refills. Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Unit Dose Medications. A charge for Prescription Drugs, such as Nicotrol Inhaler / Nasal Spray (Zyban), nicotine gum or smoking deterrent patches, for smoking cessation.

Vitamins. Charges for vitamins, except for Legend Drug vitamins, minerals and nutrient supplements.

Workers compensation. Prescriptions which an eligible Covered Person is entitled to receive without charge from any Workers' Compensation Laws, or any municipality, state or federal program.

DELTA DENTAL - DENTAL BENEFITS

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 bargaining unit contracts, date of hire, or participant contributions.

If the Plan Document does NOT list or describe a service or supply or specifically exclude the service or supply, the service or supply is NOT necessarily covered and may NOT be eligible under the Plan of Benefits.

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

Delta Dental of New Jersey, Inc. is the Claims Administrator.

Network: The network of providers is Delta Dental of New Jersey.

How to Use Your Program

Before visiting the *dentist*, check to see whether your *dentist* participates with Delta Dental in your program

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him or her your group's name and group number, as well as your Social Security number or Alternate ID.

After your *dentist* performs an examination, he or she may submit a *Pre-Treatment Estimate* of benefits to Delta Dental to determine how much of the charge will be your responsibility.

Before treatment is started, be sure you discuss with your *dentist* the total amount of his or her fee. Although *Pre-Treatment Estimates* are not required, Delta Dental strongly recommends you ask your *dentist* to submit a *Pre-Treatment Estimate* for treatment costing $300 or more. This is especially important when using a *non-participating dentist* because the *Pre-Treatment Estimate* lets you know in advance how much of the costs are your responsibility. Please keep in mind that *Pre-Treatment Estimates* are only estimates and not a guarantee of payment.

Locating a *Dentist*

Delta Dental offers two easy ways to locate a *participating dentist* **24 hours a day, 7 days a week**. Subscribers can either:

- Call 1-800-DELTA-OK (1-800-335-8265)
- Search the Internet at www.deltadentalnj.com

By calling the toll-free number, you can obtain a customized list of *participating dentists* within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you can obtain a list of *participating dentists* in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Delta Dental *participating dentists* within a designated area. You can specify listings of *general dentists* only or specialists only. *Participating dentist* information can be obtained for *dentists* nationwide.

Why Select a *Participating Dentist*?

All Delta Dental *participating dentists* have agreed, in writing, to abide by Delta's claims processing procedures. Through their commitment and support, Delta, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- *Participating dentists* have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the *Notification of Delta Dental Benefits*.

- *Participating dentists* will usually maintain a supply of *claim forms* (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.

- *Participating dentists* will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a *Pre-Treatment Estimate*, and require that you sign the *claim form* in the appropriate place. For *dentists* who submit claims electronically to Delta Dental, you will need to authorize your *dentist* to maintain your signature on file.

- *Participating dentists* will mail, fax, or electronically submit the *claim form*, together with the appropriate diagnostic materials, directly to our offices for processing.

- *Participating dentists* agree to abide by Delta Dental processing policies. For example, *participating dentists* agree not to bill separate charges for infection control measures. *Non-participating* dentists are not bound by such policies.

- *Participating dentists* will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the *treatment plan* which is covered by your dental program. You will receive a *Notification of Delta Dental Benefits* with a detailed description of covered benefits and the amount of your obligation.

- If you visit a *non-participating dentist*, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your *dentist* to confirm whether he or she participates in the Delta Dental program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our programs.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES	Group 0306-Plan A	Group 0309-Plan B
Preventive & Diagnostic Services (No Deductible)	100%	100%
Exams, Cleanings, (each twice in a twelve-month period per person, ages 14 and older are considered adults)		
X-rays-full mouth series or panoramic (either one, once in three years)		
X-rays-bitewing (twice in a twelve-month period)		
X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series)		
Fluoride Treatment (for eligible children to age 19, combinations with cleanings are applied to time limits for both)		
Space Maintainers (once per space for missing posterior primary teeth, for children under age 14)		
Consultations are counted as exams for purposes of frequency limitations		
Remaining Basic (After Deductible)	70%	70%
Fillings - composite and amalgam (composite fillings on back teeth are given the alternate benefit of an amalgam filling, payable once per year for decay or fracture only)		
Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier)		
Endodontics (root canals on permanent teeth and root surgery each once per 24 months)		
Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended - e.g. surgery once per 36 months)		
Sealants (1st and 2nd permanent, decay-free molars, once in a lifetime per tooth, for children to age 16)		
Prosthodontics & Crowns (After Deductible)	50%	50%
Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older)		
Bridgework (once every five years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture)		
Full & Partial Dentures (either one, once every five years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only)		
Repair of Dentures (Repair of existing prosthetic appliances)		
Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an amalgam filling)		
Calendar Year Maximum (per person)	$ 1,000.00	$ 1,000.00
Calendar Year Deductible		
▪ Individual	$ 50.00	$ 50.00
▪ Family (family deductible is accumulated by individual deductibles)	$ 150.00	$ 200.00

Orthodontia (Dependent Children Only)	N/A	50%
Orthodontic treatment is a benefit limited to once in a lifetime.		
▪ Maximum (Lifetime)	N/A	$ 1,000.00
▪ Deductible (Lifetime)	N/A	N/A

Under all programs, non-participating dentists may balance bill above the maximum allowable charge.

Orthodontic Payment Schedule

Payment for comprehensive orthodontics will be processed in two (2) equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered).

The first payment will be made upon insertion of appliances. The second and final payment will be made upon the completion of the first twelve (12) months of treatment. These payments will represent Delta Dental's full liability.

When the appliances are inserted prior to the effective date of eligibility, orthodontic benefits will be *pro-rated*.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

DENTAL PLAN LIMITATIONS AND EXCLUSIONS

Administrative costs. Administrative costs of completing claim forms or reports or for providing dental records.

Broken appointments. Charges for broken or missed dental appointments.

Educational Services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.

To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.

Excluded under Medical. Services that, to any extent, are payable under any medical expense benefits of the Plan.

Services for injuries or conditions which are compensable under Workers Compensation Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.

Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).

Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).

Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)

Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.

Procedures to achieve minor tooth movement.

Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.

Services rendered by anyone who does not qualify as a fully licensed *dentist*.

Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.

Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.

Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.

Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.

Procedures or preparations that are part of or included in the final restoration (bases, acid etch, or micro abrasion).

Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.

Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.

Post removal (not in conjunction with root canal therapy).

Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.

Separate fee for infection control and OSHA compliance.

Maxillofacial surgery and prosthetic appliances.

Replacement of lost or stolen appliances.

Services that are not included in the list of covered dental services.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

DELTA DENTAL – GLOSSARY OF TERMS

Glossary Term	Definition
Alternate Benefit	A provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed. Patient financial liability is dependent upon the treatment chosen.
Amalgam	A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.
Birthday Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a calendar year is considered primary.
Bitewing	A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.
Calendar Year	For benefit determinations based on a calendar year, this refers to the period of one year beginning with January 1 and ending December 31.
Claim Form	The paper form the dentist must file for reimbursement for services rendered.
COB	Coordination of Benefits. A method of integrating benefits payable under more than one plan.
COBRA	Consolidated Omnibus Budget Reconciliation Act. A law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their dependents who have had their health insurance coverage terminated.
Completion Date	The date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.
Composite	White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of amalgam.
Consultation	A discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.
Contract Year	A period of one year beginning with the effective date of the group contract.
Covered Family Members	You and your spouse and dependent children who are covered under this program.
Deductible	The amount of dental expense your group requires you to pay before Delta Dental assumes any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program.

DeltaPremier	Delta Dental's traditional fee-for-service dental benefits program.
DeltaPreferred Option	Delta Dental's basic preferred provider option (PPO).
DeltaAdvantage Plus Program	Delta Dental's enhanced preferred provider option (PPO) where the patient receives the benefits of the Advantage program when the patient is treated by an Advantage dentist and the advantages of the DeltaPremier program when the patient is treated by a DeltaPremier dentist who does not participate in Delta's Advantage Program.
DeltaAdvantage Program	Delta Dental Plan of New Jersey's enhanced preferred provider option (PPO).
Delta USA	A line of national benefits programs for clients with enrollees in more than one state: DeltaPremier USA, DeltaPreferred Option USA, and DeltaCare USA
Dentist	A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.
Endodontist	A dentist who specializes in diseases of the tooth pulp, performing such services as root canals.
General Dentist	A dentist who provides a full range of dental services for the entire family.
Gender Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the gender of the parents. The dental benefits program of the parent of a specified gender is considered primary.
IVR	Interactive Voice Response system. Information can be accessed by touch-tone telephone 24 hours a day on: eligibility, benefits, claim information, and ordering claim forms.
Maximum Benefit	The maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.
Non-Participating Dentist	A state-licensed dentist who does not have a written participation agreement with Delta Dental.
Notification of Delta Dental Benefits	A statement that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information. Also referred to as an EOB (Explanation of Benefits) or Notification of Payment (NOP).
Oral Pathologist	A dentist who is concerned with recognition, diagnosis, and management of the diseases of the mouth, jaws, and surrounding structures.
Oral Surgeon	A dentist who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and performs surgery on the mouth, jaws, and surrounding structures.

Orthodontist	A dentist who corrects misaligned teeth and jaws, usually by applying braces.
Participating Dentist	A state-licensed dentist who has a written agreement with a Delta Dental Plan to perform services and receive payment under this program.
Participating Specialist	A participating dentist with Delta Dental Plan of New Jersey who holds a specialty permit in endodontics, periodontics, prosthodontics, oral surgery, or orthodontics; limits his/her practice to that specialty; and has registered with Delta Dental as a specialist.
Pediatric Dentist	A dentist who generally limits his/her practice to children and teenagers and the handicapped. Also known as Pedodontist.
Periodontist	A dentist who treats diseases of the gums.
Pre-Treatment Estimate	Pre-authorized estimate of services detailing payment of allowable benefits.
Prevailing Fee	The lowest fee for a single procedure which equals or exceeds the fee for that procedure which Delta Dental has determined will satisfy the majority of dentists in the pertinent geographic location.
Prophylaxis	Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a dentist or dental hygienist.
Pro-rated	For subscribers whose orthodontic coverage begins after treatment has begun, payments are divided proportionately over the course of the treatment and Delta Dental's payment is based on the portion during which the subscriber has coverage.
Prosthodontist	A dentist who generally specializes in ways to replace missing natural teeth with bridges and dentures.
Sealant	An adhesive material bonded to the tooth surface to retard decay by shielding the tooth from exposure to the oral environment. This includes preventive resin restorations.
Table of Allowance Program	A program under which a group's table of allowances represents the maximum fees which are recognized for benefit purposes by Delta Dental. The patient's out-of-pocket liability will depend upon the particular program in which the patient is covered.
Treatment Plan	A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.
UCR	The Usual, Customary, and Reasonable fee level as determined by Delta Dental for the pertinent geographic location.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the appropriate Claims Administrator at the address listed below:

AETNA HEALTH INC.
P.O. Box 981107
El Paso, TX 09998-1107

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054
Attn: Claims Department

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

(c) in no event will a claim for any expenses or charges be considered eligible when submitted past the one-year period following the conclusion of the Fund Year.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW AND APPEAL PROCEDURES

Grandfathered Plans

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

(a) Request from the Claims Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

Aetna Appeals Resolution Team
PO Box 14463
Lexington, KY 40512

UnitedHealthcare Member Inquiry / Appeal
PO Box 30432
Salt Lake City, UT 84130 - 0432

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Plan Participant with a written response within 60 days of the date the Claims Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the Plan Participant's written request for review.

The Claims Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

The Plan Participant may further appeal the Claims Administrator review of denial by sending a written request to the Plan. Such request must include a copy of the original claim and/or Explanation of Benefits, the written request to the Claims Administrator for a review of original claim denial, the Claims Administrators written response to the review, and any additional information the Plan Participant may deem appropriate including medical reports. This information should be sent to the Program Manager’s Office.

The Vozza Agency
Office of the Program Manager
PO Box 100
77 Market Street
Park Ridge, NJ 07656

The request for appeal should be mailed within 60 days after the notification of the Claims Administration review determination.

The Program Manager shall place the request on the agenda for a closed session discussion at the next regularly scheduled meeting of the Fund, unless the appeal is received 7 business days or fewer prior to the next meeting, in which case it shall be placed on the ensuing meeting agenda. If, because of extenuating circumstances or additional information is required, the appeal may be delayed until the following Fund meeting. The Plan Participant will be notified in writing of the delay and advised of the meeting date.

If the Plan Participant is dissatisfied with the Fund's determination, the Plan Participant may appeal the determination to the independent appeal organization designated by the Fund for a non-binding determination.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

CLAIMS REVIEW PROCEDURE

Non-Grandfathered Plans

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant, orally or in writing 24 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

- Notification to claimant, orally or in writing 24 hours
- Response by claimant, orally or in writing 48 hours
- Benefit determination, orally or in writing 48 hours
- Notification of Adverse Benefit Determination on Appeal 72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

APPEALS PROCEDURES

Non-Grandfathered Plans

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(1) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

Non-Grandfathered Plans

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.
The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility.

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.

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 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 Medicare.

(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 it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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 Full-Time 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 is to be the primary payer, 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 both of these parts.

(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.

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 Claims 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.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the charges. Accepting benefits under this Plan for those incurred expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred expenses automatically assigns to the Plan the Covered Person's Third-Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect benefit charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for benefit expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for benefit charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan. The Plan has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under North Jersey Municipal Employee Benefits Fund, Township of West Milford (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Employer is Township of West Milford, 1480 Union Valley Road, West Milford, New Jersey, 07480, COBRA continuation coverage for the Plan is administered by Public Entity Risk Management Administration, Inc., 9 Campus Drive, Suite 16, Parsippany, NJ 07054. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Township of West Milford or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the

FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Township of West Milford for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Township of West Milford of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Township of West Milford or its designee has been timely notified that a Qualifying

Event has occurred. The employer (if the employer is not the Plan Sponsor) will notify the Plan Sponsor of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Township of West Milford or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Township of West Milford or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Township of West Milford.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Township of West Milford
1480 Union Valley Road
West Milford, New Jersey 07480

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Township of West Milford or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or

dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Township of West Milford or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Township of West Milford or its designee must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined

under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Township of West Milford or its designee with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. North Jersey Municipal Employee Benefits Fund, Health Care Plan, Township of West Milford is the benefit plan of the Township of West Milford. The North Jersey Municipal Employee Benefits Fund serves as the Plan Administrator, in accordance with the provisions of N.J.S.A. 40A:10-36 et.seq. The Township of West Milford is the Plan Sponsor.

The Plan Administrator shall administer this Plan in accordance with the Fund's By-Laws and Risk Management Plan, or as approved by the State of New Jersey Department of Insurance pursuant to N.J.S.A 40A:10-36 et.seq. The Plan Administrator shall administer this Plan based on established policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

DUTIES OF THE PLAN ADMINISTATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer, which may result from participant premium contributions.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third-Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

North Jersey Municipal Employee Benefits Fund, Health Plan, Township of West Milford

TAX ID NUMBER: 22-6002392

PLAN EFFECTIVE DATE: January 1, 1995; Revisions January 1, 1997, 2003, 2005; Plan Restated: February 2007; Restated October 2017.

PLAN YEAR ENDS: December 31st.

PLAN SPONSOR
EMPLOYER INFORMATION

Township of West Milford
1480 Union Valley Road
West Milford, New Jersey 07480

PLAN ADMINISTRATOR
AGENT FOR SERVICE OF LEGAL PROCESS

North Jersey Municipal Employee Benefits Fund
c/o Public Entity Risk Management Administration, Inc.
9 Campus Drive
Suite 16
Parsippany, NJ 07054

CLAIMS ADMINISTRATOR

Aetna Health Inc.
PO Box 981107
El Paso, Texas 09998-1107

UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

Delta Dental of New Jersey, Inc
PO Box 222
Parsippany, NJ 07054

Express – Scripts, Inc
PO Box 390873
Bloomington, MN 55439-0873

BY THIS AGREEMENT, North Jersey Municipal Employee Benefits Fund, Township of West Milford is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Township of West Milford on or as of the day and year first below written.

By _____
Township of West Milford

Date _____

Witness _____

Date _____