AETNA PPO OPTION 3 EXCLUSIONS

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

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

Ambulance in the case of a non-Medical Emergency.

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

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

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

Broken Appointments.

Completion of Claim Forms or requests for Medical Records.

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

Consumable medical supplies.

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

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

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

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

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

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

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

Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable 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. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

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

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

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

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

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

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

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

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

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

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

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

Immunizations unless otherwise stated in this Booklet.

Light box therapy and the appliance that radiates the light.

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

Methadone maintenance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment, except when specifically approved by your plan, or when mandated.

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

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

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

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

Therapies considered as **maintenance**.

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

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

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

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

Weight Loss clinics, health clubs and similar programs.

VISION BENEFITS

Vision Benefits are administered by Qualcare Inc. Not all participants may be eligible for all Schedule of Benefits described in this section. Enrollment in specific Schedule of Benefits or Plans may be subject to union contracts, date of hire, or participant contributions.

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:
Before covered. Care, treatment or supplies for a charge incurred before a person was covered under this Plan.
Excluded. Charges excluded or limited by the Plan design as stated in this document.
Health plan. Charges covered under a health plan that reimburses a greater amount than this Plan.
No prescription. Charges for lenses ordered without a prescription.
Orthoptics. Charges for orthoptics (eye muscle exercises).
Sunglasses. Charges for safety goggles or sunglasses, including prescription type.
Training. Charges for vision training or subnormal vision aids.

VISION CARE BENEFIT SCHEDULE

Examinations -	Limited to Once every 24 months	
	Benefit:	$30
Lenses -	Limited to Once every 24 months	
	Single Lens Benefit:	$60
	Bifocal Lens Benefit:	$69
	TriFocal Lens Benefit:	$75
	Leticular Lens Benefit:	$96
Contact Lenses -	Limited to Once every 24 months	
	Contact Lens Benefit:	$180 (based on medical necessity)
Frames -	Limited to Once every 24 months	
	Benefit:	$60

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating Retail pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts, Inc. is the administrator of the pharmacy drug plan. Not all participants may be eligible for all Schedule of Benefits described in this section. Enrollment in specific Schedule of Benefits or plans may be subject to union contracts, date of hire, or participant contributions.

If a drug is purchased from a non participating pharmacy, or a participating retail 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.

Copayments

If applicable to your plan, a copayment is applied to each covered retail pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy prescription is limited to the greater of 34 days supply or 100 units. Any one mail order prescription is limited to a 90 days supply. Specialty Pharmaceuticals are limited to a 30 day supply.

Percentages Payable

If applicable to your plan, the percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. This amount is not a covered charge under this Plan or the medical plan.

Mail Order Drug Benefit

The mail order drug benefit 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.). All mail order prescriptions are filled by registered pharmacists who are available for emergency consultations on a 24 hour, 7-day a week basis. Mail Order may have the convenience of auto-fill of regular prescriptions via the internet, telephone, fax or mail. Auto fills on these prescriptions have proven to increase overall compliance reducing visits to the emergency room.

Specialty Pharmaceutical

Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. Examples of prescription drugs that qualify as specialty pharmaceuticals include, but are not limited to, those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; or Gaucher's Disease.

Specialty pharmaceuticals are provided through Accredo Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for this Prescription Drug Plan.

You will not be able to fill the prescription for a speciality pharmaceutical through a retail pharmacy. To fill a speciality prescription, contact Accredo Specialty Pharmacy at **800-803-2523 (phone)**. Accredo will work with you and your provider to arrange for delivery of your prescription as well as provide any special instructions regarding the administration.

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 at **800-753-2851 (phone)** or **800-357-9577 (fax)** 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 participant 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 maintains compliance of dosage.

COVERED PRESCRIPTION DRUGS

The following are covered benefits unless listed as Prescription Plan Exclusion:

- All eligible 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 this Plan.
- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity and meet the required clinical guidelines set forth by the Prescription Benefit Manager (PBM).
- Insulin and other diabetic supplies when prescribed by a Physician.

Limits to This 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.

Medicare Part B

The Group Medicare Advantage PPO Plan shall provide coverage for all Medicare approved Part B Prescriptions. Non-Medicare approved prescriptions may be eligible under this plan of benefits. All non-Medicare eligible prescriptions covered under this plan must adhere to the policies and procedures of this plan.

PRESCRIPTION PLAN EXCLUSIONS

This benefit will not cover a charge for any of the following. As drugs are introduced or removed from the market, prescribing patterns may adjust to preferred medical practices. Please contact the Claims Administrator for specific, updated drug coverage.

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.

Consumed on premises. Any drug or medicine that is consumed or administered at the place where it is dispensed.

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.

Drugs used for cosmetic purposes. Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

Drugs dispended by an unlicensed pharmacy.

Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and physician offices.

Drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by another Drug or Medical Service for which no charge is made to the member.

Drugs supplied in Unit Doses packaging except when that is the only form distributed to pharmacies.

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.

Formulary Exclusions. Drugs identified on the Fund's formulary as exclusions.

Growth hormones. Charges for drugs to enhance physical growth or athletic performance or appearance.

Immunization. Immunization agents or biological sera.

Injectable supplies. A charge for hypodermic syringes and/or needles (other than for insulin).

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.

Prescription drugs that do not meet **medical necessity** and appropriateness criteria.

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.

Professional charges in connection with administering, injecting, or dispensing of drugs.

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.

Quantities in excess of dispensing limits.

PRESCRIPTION DRUG DEFINED TERMS

Ancillary Charge — a charge in addition to the Copayment and/or Deductible amount which the Member is required to pay a Participating Pharmacy for a covered Brand-name Prescription Drug Product for which a Generic substitute is available as identified on the Maximum Reimbursement Amount ("MRA") List. The Ancillary Charge is calculated as the difference between the Client Contract Rate for the Brand-name Prescription Drug Product dispensed and the MRA price of the Generic substitute. Varying dispensing laws may or may not allow a pharmacist to dispense a Generic without consulting the physician.

Benefit Plan Level — the defined benefits a Member is entitled to receive under a benefit plan

Chemical Equivalents — multi-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and which meet existing FDA physical/chemical standards.

Compound Drug — a drug prepared by a pharmacist using a combination of drugs in which at least one agent is a legend drug. The final product is typically not commercially available in the strength and/or dosage form prescribed by the physician.

Concurrent DUR — are on-line, real time edits using the claims database to help identify potential drug-related problems. Alerts are transmitted from Express Scripts to the dispensing pharmacist at a Participating Pharmacy (retail and mail) and allow Express Scripts to document the intervention and outcomes that occur. Concurrent DUR modules available include edits for drug-drug interactions, maximum daily dose, therapeutic/ingredient duplication, drug-age management, drug protocol management by gender, and other relevant drug-related problems. These edits should not be confused with numerous other edits in the Express Scripts system to limit days supply, early refill requests, quantity per day limit.

Contract Year — a one year period, beginning with the effective date of the group benefit contract and each anniversary thereof, as specified by Client.

Covered Drug(s) — Those prescription drugs, supplies, and other items that are covered under this Prescription Drug Plan as indicated on the EBD.

DAW (Dispense as Written) — a physician directive not to substitute a product. Members may be required to pay an Ancillary Charge for DAW prescriptions, depending on the ancillary policy applicable under the benefit plan.

Deductible — the amount of eligible expenses a Member must pay from his/her own pocket before the benefit plan will pay for eligible benefits; the Deductible may apply on a monthly, quarterly, yearly or lifetime basis.

Dispensing Quantity Limit — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).

Drug Quantity Management — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.

Drug Utilization Review (DUR) — Drug utilization reviews are performed by ESI to determine a prescription's suitability in light of the patient's health, drug history, drug-to-drug interactions, and drug contraindications.

Federal Legend Drug — A drug that, by law, can be obtained only by prescription and bears the label, Caution: Federal law prohibits dispensing without a prescription.

Maintenance Medications — a Maintenance Medication list is a list of drug products, typically used for chronic conditions, approved by the client for dispensing in quantities or day supplies (e.g. 90 days) other than the standards covered under a benefit plan. The Drug Quantity Management List will override this supply limit. The Maintenance List applies to the retail program only, and applies to both claims submitted by Participating Pharmacies and Members. If a mail order program has been implemented, a Maintenance List is typically not implemented.

Maximum Out-of-Pocket (MOPS) — the limit on a Member's total Copayments and/or Deductibles under a benefit plan with respect to outpatient Prescription Drug Products.

Medical Necessity and Appropriateness — Medical necessity and appropriateness criteria and guidelines are established and approved by the National Pharmacy and Therapeutics Committee (NP&T Committee), which consists of practicing physicians and pharmacists. Eligible prescription drugs must meet federal Food and Drug Administration (FDA) approved indications and be safe and effective for their intended use. Drugs administered by a medical professional are not eligible under this plan.

A prescription drug is medically necessary and appropriate if, as recommended by the treating practitioner and as determined by the NP&T Committee or designee(s) it is all of the following:

- A health intervention for the purpose of treating a medical condition;
- The most appropriate intervention, considering potential benefits and harms to the patient;
- Known to be effective in improving health outcomes (For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence; then if necessary, by professional standards; then, if necessary, by expert opinion);
- Cost effective for the applicable condition, compared to alternative interventions, including no intervention. Cost effective does not mean lowest price.

The fact that an attending practitioner prescribes, orders, recommends, or approves the intervention, or length of treatment time, does not make the intervention medically necessary and appropriate.

National Drug Code (NDC) — a national classification system for identification of drugs. Similar to the Universal Product Code (UPC).

Over-the-Counter (OTC) drug — a drug product that does not require a Prescription Order under federal or state law.

Prescription Drug Product — a medication, product or device approved by the FDA and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under Client's plan, this definition may also include insulin and certain diabetic supplies and over-the-counter medication, products or devices if dispensed pursuant to a Prescription Order or Refill.

Prescription Order or Refill — the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization (PA) — the process of obtaining certification of coverage for certain Prescription Drug Products, prior to their dispensing, using guidelines approved by the Client.

Step Therapy — Step therapy encourages a trial of less costly first-line prescription drugs before the use of more costly second line agents. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.

Therapeutic Equivalent — a medication that can be expected to have the same clinical effect and safety profile when administered under the conditions specified in labeling as another medication, although the medications are not Chemical Equivalents.

Unit Dose Medications — medications packaged in individual unit-of-use blister packs. Unit dose medications tend to be more expensive. Pharmacies providing medications to long-term care facilities are often required to dispense in unit dose packaging. Products available only in unit dose are covered regardless.

Usual and Customary (U&C) Charge — the usual and customary price charged by a Pharmacy for a Prescription Drug Product dispensed to a cash paying customer.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

RX PLAN	RETAIL Copay-Coinsurance	MAIL ORDER Copay-Coinsurance	SPECIALTY Copay	DEDUCTIBLE	MAX OUT OF POCKET
	Generic / Formulary Brand / Non-Formulary Brand	Generic / Formulary Brand / Non-Formulary Brand	Limited to a 30 Day Supply	Per Person / Family	Per Person / Family
0831-0002	$15 / $15 / $15	$15 / $15 / $15	See Retail Copay	$0 / $0	$3,000 / $6,000
RX for Aetna Plans	$10 / $20 / $30	$20 / $40 / $60	See Retail Copay	$0 / $0	$1,500 / $3,000

DENTAL PLAN

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. Not all participants may be eligible for all Schedule of Benefits described in this section. Enrollment in specific Schedule of Benefits or plans may be subject to union contracts, date of hire, or participant contributions.

This benefit applies when a person while covered under this Plan incurs covered dental charges.

Delta Dental of New Jersey, Inc. is the Claims Administrator and Network.

How to Use Your Program

Before visiting the dentist, check to see whether your dentist participates in the Delta Dental plan/program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our plans/programs.

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him/her your group's name and group number, as well as your Social Security number. Your dependents, if covered, also must give your Social Security number.

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.

DENTAL BENEFITS
Why Select a Participating Dentist?

All Delta Dental *participating dentists* have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, 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.

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. The Schedule of Benefits illustrate eligible services, frequency and age limits according to accepted standards of dental practice. Additional reimbursements may be considered when dental and medical necessity are determined. Additional reimbursements shall never exceed the calendar year maximum benefit amount as stated in the Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits. Your maximum benefits payable are either based on a calendar year or a coverage period (determined by your employer). All procedures that are paid by Delta Dental will be applied to your plan maximum. If your contract provides benefits for orthodontia or other specific benefits such as TMJ coverage, they may have their own separate annual or lifetime limits. In addition, you may have an individual annual maximum or a combined family maximum for everyone under your coverage.

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.

SCHEDULE OF DENTAL BENEFITS

	601-0227	
Calendar Year Maximum (per person)	$1,000	
Calendar Year Maximum (per family)	N/A	
Calendar Year Deductible (per person)	N/A	
Calendar Year Deductible (per family)	N/A	
Preventive & Diagnostic	100%	
Remaining Basic	80%	
Crowns/Inlays	80%	
Prosthodontics	50%	
Implants	Not Covered	
Orthodontia - Coverage for dependent children to age 23 only If covered, orthodonic treatment is limited to once per lifetime.	70%	
Orthodontic Maximum (Lifetime)	$2,000	
Orthodontic Deductible (Lifetime)	N/A	

Refer to previous page for more information Benefit Payments and Services

COVERED CHARGES

Services subject to age, frequency and other limations - contact your administator for details

- Exams, Cleanings - twice per calendar year
- Fluoride Treatment - once per calendar year
- Sealants
- Xrays
- Space Maintainers
- Fillings
- Extractions
- Endodontics
- Periodonics
- Oral Surgery
- Crowns, Inlays and Restorations
- Bridgework
- Dentures/Repair of Dentures

ORTHODONTIC PAYMENT SCHEDULE

This schedule applies to plans that include coverage for orthodontia. See summary of benefits for orthodontia coverage.

If orthodontics are covered, 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 EXCLUSIONS

Exclusions and Limitations: Services not covered by this plan

Administrative costs of completing claim forms or reports or for providing dental records.

Charges for broken or missed dental appointments.

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.

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.

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.

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 which are part of or included in the final restoration (bases, acid etch, or micro abrasion).

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.

Transplants, implants and procedures directly associated with implants, including crowns and bridgework and their restoration and their maintenance or repair, except where specifically stated as covered in the Plan's Schedule of Benefits.

Orthodontic Treatment and/or Appliances to correct a malocclusion of the mouth, except where specifically stated as covered in the Plan's Schedule of Benefits.

DENTAL 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.

Alternate Benefit is 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 is 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 is the coordination of benefits regulation stipulation 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 is a dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

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

Carryover Max Feature is a benefit option that enables Covered Persons to carry over part of the unused standard maximum benefit in one coverage period to increase the amount of benefits available in the subsequent coverage periods subject to certain requirements and limitations.

Claim Form is the paper form the dentist must file for reimbursement for services rendered.

COB is the Coordination of Benefits and a method of integrating benefits payable under more than one plan.

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

Completion Date is 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 is the 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 is a discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.

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 or Dependent who is covered under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

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

Employer is Borough of Atlantic Highlands.

Endodontist is a dentist who specializes in diseases of the tooth pulp, performing such services as root canals.

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 dental community or government oversight agencies at the time services were rendered.

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

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

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

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

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

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

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

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

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

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

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 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 or 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 or Dentist recommends or approves certain care does not mean that it is Medically Necessary.

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

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

Oral Health Enhancement Option is a benefit option that provides coverage for additional dental cleanings and periodontal maintenance procedures beyond the normal frequency limits for Covered Persons who received certain periodonal services in the past.

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 Outpatient Surgical Center, or the patient's home.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), 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 Borough of Atlantic Highlands, Central Jersey Health Insurance Fund, which is a benefits plan for certain Employees of Borough of Atlantic Highlands 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.

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.

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 pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

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

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator 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, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician 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 Claims Administrator at this address:

Aetna Health Inc.
P.O. Box 981107
El Paso, TX 09998

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054-0222

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.

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.

PROCESSING CLAIMS AND APPEALS

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.

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 of Claim determination	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 Claims	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 for non-Urgent Claims	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 Predetermination of Benefits or 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, 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.

(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

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.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action following an Adverse Benefit Determination on review.

(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

This plan is not governed by ERISA therefore the following claim appeal procedure has been established under the Plan as a member of the Central Jersey Health Insurance Fund.

After exhausting the claim appeal process directly with the Claims Administrator, the Plan Participant may further appeal the Claims Administrator review of denial by sending a written request to the Plan within thirty (30) days of the Adverse Benefit Determination. Such request must include a copy of the original claim and/or Explanation of Benefits, the written request to the Plan 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. The Plan Participant may provide written authorization to reveal the identity of the Plan Participant. This information should be sent to:

PERMA Risk Management Services
c/o 401 Route 73 North
Suite 300
Marlton, NJ 08053

Should a participant fail to submit an appeal within the thirty (30) day period, the Adverse Benefit Determination shall become final and irrefutable.

The Claim Appeal shall be place 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 exercising any other remedies provided by law.

COORDINATION OF BENEFITS

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

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

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

Allowable Charge. For a charge to be allowable 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. If the HMO is the Primary Plan that does not permit the services of Out of Network Providers with the exception of urgent care and/or medical emergency and the service provided by the Out of Network Provider is not considered as urgent care and/or medical emergency; then the Secondary Plan shall pay the eligible benefits as if the Plan was Primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental 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 medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental 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 or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental 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 medical or dental 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 medical or dental 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 medical or dental 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 medical or dental 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 medical or dental 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 medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental 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 medical or dental 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 medical or dental 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 Administrator. The Plan Administrator 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 Borough of Atlantic Highlands, Central Jersey Health Insurance Fund (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 Plan Sponsor is Borough of Atlantic Highlands, 100 First Avenue, Atlantic Highlands, NJ, 07716. COBRA continuation coverage for the Plan is administered by PERMA LLC, c/o Benefit Express, P.O. Box 189, Arlington Heights, Illinois 60006, 523-793-3766. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator 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 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., common-law employees (full or part-time), 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 Civil Union partner and his or her children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the Civil Union partner and children the contractual rights outlined in this Section but does not extend statutory provisions to the Civil Union partner or child.

Federal law does not recognize a Civil Union Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Civil Union Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Civil Union Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Civil Union Partner ceases to be met. This gives the Civil Union Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

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 Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a 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 Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator 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) entitlement of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of Civil Union partnership 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 Plan Administrator 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 Plan Administrator 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 Plan Sponsor.

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:

Borough of Atlantic Highlands
100 First Avenue
Atlantic Highlands, NJ 07716

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 Plan Administrator 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 Plan Administrator 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