PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

BOROUGH OF ATLANTIC HIGHLANDS CENTRAL JERSEY HEALTH INSURANCE FUND

AETNA PPO OPTION 3

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INTRODUCTION

This document is a description of Borough of Atlantic Highlands employee health benefits through the Central Jersey Health Insurance Fund (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Each benefit may have distinctive provisions and a separate document, if applicable. Please refer to the Schedule of Benefits including limits, cost management and exclusions for each benefit. Not all participants may be eligible for all Schedule of Benefits described in this document. Enrollment in specific Schedule of Benefits or plans may be subject to union contracts, date of hire, or participant contributions. A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

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

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

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

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

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

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer. The following Classes of Employees:

(1) All Active Employees of the Employer meeting the eligibility requirements.

(2) Retired Employees are not eligible for coverage.

(3) Approved by Resolution.

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

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

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation pay, etc.). For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices. For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least 3 but not more than 12 consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods).

(2) Retired Employees are not eligible for coverage.

(3) is in a class eligible for coverage.

(4) completes the employment Waiting Period of active employment:
The first day of the month following 60 days of continuous employment.
A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

(5) Eligibility as described and approved by Resolution.

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

(1) A covered Employee's Spouse or Civil Union Partner.

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

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

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, adopted child, step child or a child placed with the Employee for adoption.

-MEDICAL and RX Benefits for Employee's Children:
An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the covered child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

- DENTAL Benefits for Employee's Children:
An Employee's Child will be an Eligible Dependent if unmarried and primarily dependent on the Employee for support and maintenence until the limiting age of 23. When the covered child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

(3) A covered Employee's Qualified Dependents.

The term "children" shall include foster children or children for whom the Employee is a Legal Guardian who reside in the Employee's household.

Foster Child means an unmarried child under the limiting age whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's child/children; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

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

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be unmarried, under the limiting age of 26 years, (limiting age of 23 for dental coverage), living with the Employee and primarily dependent upon the covered Employee for support and maintenance. When a Qualified Dependent reaches the applicable limiting age, coverage will end at the end of the Calendar Year. In the case of Dental, when the covered child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

If a covered Employee or Spouse is the Legal Guardian of an unmarried child or children, under the limiting age of 26 (limiting age of 23 for dental coverage), and primarily dependent upon the Employee for support and maintenance, these children may be enrolled in this Plan as Qualified Dependents.

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

(4) Chapter 375, P.L. 2005 to cover Over Age Children under age 31 does not apply to this Plan.

(5) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried may remain on this

plan until the individual is eligible for other coverage. If other coverage is available to the individual then the individual will be considered enrolled and not be eligible under this Plan. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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

To request continued coverage, ask your Employer for a Continuance for Dependent with Disabilities form. The form and proof of the child's condition must be given to the Employer no later than 31 days after the date coverage would normally end.

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father. Claims will never be paid more than 100% of eligible allowance of charges.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. Coverage for dependent children is effective from birth and all enrollment requirements have been met.

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

Eligibility Requirements for Retired Employees and Other Medicare Eligible Persons.

This Plan requires that Covered Persons who are eligible for Medicare (Retirees, disabled persons), based on individual, spousal or former spousal eligibility, regardless of premium requirement, must be enrolled under the Medicare program for Part A / Medicare Hospital Insurance and Part B / Medicare Medical Insurance in order to be a participant under this Plan. This Plan will not pay for benefits that would have been paid by Medicare.

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

All Medicare eligible Retirees and Disabled Persons shall enroll in the Group Medicare Advantage PPO Plan. You must continue paying Medicare Part B premiums to maintain this coverage. If you stop paying your Medicare Part B premium payments, or you choose to opt out of the Medicare Advantage PPO Plan, your retiree medical coverage under the Fund will terminate and you will lose your employer-sponsored group coverage. You will retain your entitlement to Original Medicare Parts A and B. If your employer-sponsored medical coverage under the Fund terminates, you will not be able to re-enroll at a later date. The carrier will provide the plan summary for the Group Medicare Advantage PPO Plan.

Any prescription drug benefits that may be provided through the Plan are equal to or better than the benefits provided by the standard Medicare Part D plan. In that case, most Medicare eligible participants and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage.

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

FUNDING

Cost of the Plan.

Eligible Active Employees: Borough of Atlantic Highlands shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage may include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The Borough of Atlantic Highlands establishes the levels of Employee contributions and reserves the right to change the level any required contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

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

If the child is not enrolled within 60 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 60 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

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

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

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

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact Borough of Atlantic Highlands, 100 First Avenue, Atlantic Highlands, NJ, 07716.

SPECIAL ENROLLMENT PERIODS

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

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

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

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

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

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

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

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

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

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

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

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

(3) Dependent beneficiaries. If:

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

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

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

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

(a) in the case of marriage, the day of marriage;

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

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

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

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

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

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

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

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

(4) The Waiting Period.

Active Employee Requirement.

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

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

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

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

TERMINATION OF COVERAGE

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

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the covered Employee and/or Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

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

(1) The date the Plan is terminated.

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

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

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

(5) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) The last day of the Calendar Month in which employment terminates.

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

For disability leave only: for 12 months following the month the person last worked as an Active Employee. The Employer will pay the first 3 months of coverage and the Employee will bear the cost of the remaining 9 months of continued coverage.

For leave of absence or layoff only: for 12 months following the month the person last worked as an Active Employee. The Employee will bear the cost of the entire 12 months of continued coverage.

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

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

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

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

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

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

Eligible employees must provide prior notice to the employer, in compliance with the Act, if requesting a leave of absence under this Act. The employer has the right to request that an employee provide a certification issued by a health care provider in order to ensure that the employee meets the eligibility requirements. The employer may deny a request for leave made by an otherwise eligible employee, if the employee is among the highest paid five percent, or is one of the seven highest paid employees of the company, whichever is greater, and the employer can demonstrate that the leave will cause substantial and grievous economic injury to its operations.

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

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

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

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

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

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

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

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Borough of Atlantic Highlands, 100 First Avenue, Atlantic Highlands, NJ, 07716. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

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

(4) On the last day of the month that a person ceases to be a Dependent as defined by the Plan other than reaching Dependent Limiting Age. (See the section entitled Continuation Coverage Rights under COBRA.)

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

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

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

(8) On the last day of the Calendar Year in which a Dependent child reaches the limiting age as defined by the Plan. In the case of Dental, when the covered child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

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

OPEN ENROLLMENT

OPEN ENROLLMENT

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

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

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

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

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

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AETNA PPO OPTION 3 MEDICAL SCHEDULE OF BENEFITS

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

Verification of Eligibility See Back of ID card

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

MEDICAL BENEFITS

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

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

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

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

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

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

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

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider.

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

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

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

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

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

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

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

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

MAXIMUM BENEFIT AMOUNT

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

SUMMARY OF MEDICAL BENEFITS

Aetna PPO Option 3 PCP Selection Not Required	NETWORK PROVIDERS Based on Contracted Fees	NON-NETWORK PROVIDERS Based on Usual and Reasonable Fees
DEDUCTIBLE PER CALENDAR YEAR		
Per Covered Person	N/A	$1,500
Per Family Unit	N/A	$3,000
Covered Services and Supplies Incurred within the last three months of a Benefit Period which were applied against the Deductible may be carried over and applied against the Deductible for the following Benefit Period.		
PRECERTIFICATION REQUIREMENT		
Plan requires precertification of Medical Necessity for certain services before Medical and/or Surgical services are provided. Please see the Cost Management section of this booklet for more details. Failure to follow precertification procedures may reduce benefit payment by the plan. Contact your claims adminstrator for any applicable penalty amounts.		
SECOND AND/OR THIRD OPINION PROGRAM REQUIREMENT		
Second and/or third opinion program is encouraged but not required by this Plan. Please see the Cost Management section of this booklet for more details.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$1,200	$1,800
Per Family Unit	$3,000	$4,500
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the Maximum Out-of-pocket Amount and are never paid at 100%: - Cost containment penalties, Amounts over Usual and Reasonable Charges, Non-covered charges All In-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the In-Network Maximum Out-of-pocket amount. All Non-Network Out-of-pocket expenses for covered charges will accumulate to satisfy the Non-Network Maximum Out-of-pocket amount except for expenses paid toward the deductible.		
COVERED CHARGES		
Hospital Services		
Inpatient	100% covered	Subject to deductible; 60% coinsurance
Intensive Care Unit	100% covered	Subject to deductible; 60% coinsurance
Emergency Room Visit - Copayment waived if admitted		
Medical Emergency	$30 copayment	$30 copayment
Urgent Care	See Specialist visit In-Network Benefit	See Specialist visit In-Network Benefit
Skilled Nursing Facility	100% covered	Subject to deductible; 60% coinsurance
Benefit Maximum	Based on Medical Necessity	
Physician Services		
Inpatient visits	100% covered	Subject to deductible; 60% coinsurance
Office visits	$25 copayment	Subject to deductible; 60% coinsurance
Specialist visits	$35 copayment	Subject to deductible; 60% coinsurance
Maternity OB Visits	$35 copayment applies to first office visit; then 100% covered	Subject to deductible; 60% coinsurance
Surgery	100% covered	Subject to deductible; 60% coinsurance
Allergy Testing	$35 copayment	Subject to deductible; 60% coinsurance
Allergy Treatment	$35 copayment	Subject to deductible; 60% coinsurance
Diagnostic Testing (X-ray & Lab)	100% covered	Subject to deductible; 60% coinsurance
Home Health Care	100% covered	Subject to deductible; 60% coinsurance
Inpatient Prescription Drugs	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Retail - Prescription Drugs	Refer to your RX Summary of Benefits	Refer to your RX Summary of Benefits
Outpatient Private Duty Nursing	100% covered	Subject to deductible; 60% coinsurance

Aetna PPO Option 3 PCP Selection Not Required	NETWORK PROVIDERS Based on Contracted Fees	NON-NETWORK PROVIDERS Based on Usual and Reasonable Fees
Hospice Care Contact your claims administrator for any limitations that may apply	Based on Place of Service	Subject to deductible; 60% coinsurance
Ambulance	100% covered	Subject to deductible; 60% coinsurance
Jaw Joint/TMJ	Not Covered	Not Covered
Wig After Chemotherapy	100% covered	100% covered
Benefit Limit	$500 benefit maximum per 24-month period	
Occupational Therapy*	$35 copayment	Subject to deductible; 60% coinsurance
Speech Therapy*	$35 copayment	Subject to deductible; 60% coinsurance
Physical Therapy*	$35 copayment	Subject to deductible; 60% coinsurance
Benefit Limit	Based on medical necessity	
Refer to "Autism or Another Developmental Disability"in the Covered Charges section for information specific to therapy coverage associated with a diagnosis of Autism.		
Durable Medical Equipment	100% covered	Subject to deductible; 60% coinsurance
Vision Eyewear	Refer to Vision Plan in this document	Refer to Vision Plan in this document
Hearing Aid Devices	100% covered	Subject to deductible; 60% coinsurance
Benefit Limit	Coverage for persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.	
Prosthetics	100% covered	Subject to deductible; 60% coinsurance
Orthotics	100% covered	Subject to deductible; 60% coinsurance
Spinal Manipulation Chiropractic	$35 copayment	Subject to deductible; 60% coinsurance
Benefit Limit	Maximum of 30 visits per calendar year in network - Subject to medical review	
Mental Disorders		
Inpatient	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Outpatient	$35 copayment	Subject to deductible; 60% coinsurance
Substance Abuse		
Inpatient	Refer to Hospital Services - Inpatient	Refer to Hospital Services - Inpatient
Outpatient	$35 copayment	Subject to deductible; 60% coinsurance
Preventive Care		
Routine Well Adult Care	100% covered	Not Covered
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or tobacco use, colonoscopies and services for pap smear, mammogram, prostate screening, gynecological exam, screening for blood pressure, cholesterol, type 2 diabetes, HIV, immunizations/flu shots. Refer to healthcare.gov for complete listing.		
Routine Gynecological Exam	100% covered	Not Covered
Routine Mammograms	100% covered	Not Covered
Routine Well Newborn & Child Care	100% covered	Not Covered
Eligible coverage for the following listed services are subject to gender, age and frequency guidelines as well as associated risk factors. Includes: office visit for routine physical examination including counseling for obesity, alcohol and/or drug use, screening for autism, blood pressure, congenital hypothyroidism, developmental, hearing, lead, and vision, immunizations/flu shots, behavioral assessment. Refer to healthcare.gov for complete listing.		
Eye Exam Frequency limits may apply	Refer to Vision Plan in this document	Refer to Vision Plan in this document
Organ Transplants	Refer to Associated Medical Service - Contact your Claims Administrator	Refer to Associated Medical Service - Contact your Claims Administrator
Infertility Benefits	Refer to Associated Medical Service	Refer to Associated Medical Service
Benefit Limitations	Coverage subject to current New Jersey State Mandate. Treatment covered with limitations. Contact your Claims Adminstrator for more details	

AETNA PPO OPTION 3 COVERED CHARGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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

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

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

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

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

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

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

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

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

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

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

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

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

Autism or Another Development Disability:

- Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
- Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another

developmental disability. Visitation limits for therapies do not apply for individuals diagnosed with autism;

- Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals diagnosed with autism;
- A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

ABA therapy is not eligible for individuals with developmental diagnoses.

Precertification is necessary for ABA and all other therapy services.

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

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

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

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

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

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

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

a. blood glucose monitors and blood glucose monitors for the legally blind;
b. test strips for glucose monitors and visual reading and urine testing strips;
c. insulin;
d. injection aids;
e. cartridges for the legally blind;

f. syringes;
g. insulin pumps and appurtenances to them;
h. insulin infusion devices; and
i. oral agents for controlling blood sugar.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

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

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

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

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

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

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

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

The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances, including foot orthotic, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The Plan does not cover: fabric and elastic supports; corsets; trusses; elastic hose; canes; crutches; cervical collars; or dental appliances or

other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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

Prescription Drugs (as defined).

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

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

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

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

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

This mammoplasty coverage will include reimbursement for:

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

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

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

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

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

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

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

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

Sterilization procedures.

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

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

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

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

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

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

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

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

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

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

Diagnostic **x-rays**.

AETNA PPO OPTION 3 COST MANAGEMENT SERVICES

Cost Management Services Phone Number

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

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

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

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

UTILIZATION REVIEW

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

The program consists of:

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

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

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

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

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

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

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

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

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

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

Here's how the program works.

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

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

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

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

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

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

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

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

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

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

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

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

as listed on the Employee's ID card

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

These additional consultations must be performed by Physicians who are:

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

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

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

CASE MANAGEMENT

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

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

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

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

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

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

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

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

AETNA PPO OPTION 3 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.

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

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

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

Brand Name means a trade name medication.

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

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

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

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

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

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

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

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

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

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

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

Employer is Borough of Atlantic Highlands.

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

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

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

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

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

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

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

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

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

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

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

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved

generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

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

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

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

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

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

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

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

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

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

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

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a

registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

Infertility means incapable of producing offspring.

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

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

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

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

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

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

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

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

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

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

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

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

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

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

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

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

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

Plan means 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.

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

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

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

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

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

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

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

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

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

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

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

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

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

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

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.