MIDDLESEX COUNTY
JOINT HEALTH INSURANCE FUND

HEALTH CARE CHOICE PLAN DOCUMENT

AS AMENDED AND RESTATED

EFFECTIVE 1/1/2004

NOTE: ***Specific personnel policies may affect the provisions described in this Plan Document. Please contact your Personnel Department for more information***.

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HEALTH CARE PLANS

In order to provide cost effective medical benefits to all eligible participants of the "Local Units" of Government in Middlesex County, an Agency called Middlesex County Joint Health Insurance Fund ("Fund") was created. The Fund's purpose is to provide health care benefits to all eligible participants for Medically Necessary services covered under this Plan. This booklet details, in general, what Covered Person must do to apply and receive these benefits.

In order to provide for efficient processing of health care claims, effective January 1st, 2003, the Fund uses Horizon Blue Cross Blue Shield of New Jersey. In brief, if a Covered Person needs to claim benefits, a Covered Person begins by contacting the person who has been designated to handle the benefits in this Local Unit of Government. This person will provide a Covered Person with the necessary claim forms which must be completed by the Covered Person and the Attending Physician. These forms must be submitted to Horizon Blue Cross Blue Shield of New Jersey as described in the appropriate section of this booklet called "How to Submit a Claim". Please be aware, in order to be eligible to receive benefit payment or reimbursement under this Health Care Choice Plan (the "Plan"), a Covered Person must include with the completed claim form itemized bills that adequately describe all the services rendered.

This booklet sets forth the general coverage provided under the Plan. A Covered Person is entitled to this coverage if the Covered Person is eligible in accordance with this plan document (the "Plan Document"). This booklet is void if the Covered Person has ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force.

Note that specific personnel policies may affect the provisions described in this Plan Document. Please contact your Personnel Department for more information.

Notwithstanding any other provisions of the Plan, this Plan will duplicate, in the scope and dollar amount each and every health care coverage that was provided to each Employee, Retiree, Dependent, or COBRA participant by the health care policy applicable to said persons at the time of the inception of this Plan.

This Plan shall also provide, contrary or more effective language notwithstanding, those coverages which the statutes and administrative regulations of the State of New Jersey require a Local Unit of Government, member of the Middlesex County Joint Health Insurance Fund to provide to an Employee, Retiree, Dependent or COBRA participant as the case may be.

SECTION I
SUMMARY PLAN DESCRIPTION
INTRODUCTION

SECTION I
SUMMARY PLAN DESCRIPTION

The information furnished herein is designed to acquaint the Covered Person with the benefits of this Plan which are now available to covered Employees/Retirees and their covered Dependents.

GENERAL INFORMATION

PLAN SPONSOR: (Employer)	Middlesex County Administration Middlesex County Improvement Authority Middlesex County Mosquito Commission Middlesex County Board of Social Services Middlesex County Utilities Authority Roosevelt Care Center
PLAN NAME:	This Plan shall be known as the Middlesex County Joint Health Insurance Fund, Health Care Plan, Health Care Choice Plan (Plan B)
PLAN ADMINISTRATOR:	Middlesex County Joint Health Insurance Fund
ADDRESS OF THE PLAN:	Middlesex County Joint Health Insurance Fund c/o Middlesex County Administration John F. Kennedy Square, 3rd Floor P.O. Box 871 New Brunswick, NJ 08903
FUND IDENTIFICATION NUMBER:	22-3382140
PLAN EFFECTIVE DATE:	July 1, 1995
PLAN LAST RESTATEMENT DATE:	January 2004
PLAN YEAR END:	December 31st
EXECUTIVE DIRECTOR/ ADMINISTRATOR:	Brown & Brown Consulting 2005 Market Street, Suite 3510 One Commerce Square Philadelphia, PA 19103
PLAN PROGRAM MANAGER:	Federal Hill Risk Management 1122 Kenilworth Drive, Suite 408 Towson, MD 21204
NAMED FIDUCIARY:	Middlesex County Joint Health Insurance Fund

AGENT FOR SERVICE OF LEGAL PROCESS:	Middlesex County Joint Health Insurance Fund c/o James M. Cahill, Esq. 24 Kirkpatrick Street P.O. Box 632 New Brunswick, NJ 08903
FUND ATTORNEY AND PRIVACY OFFICER	James M. Cahill, Esq. 24 Kirkpatrick Street P.O. Box 632 New Brunswick, NJ 08903
PLAN ADMINISTRATOR FOR COBRA PURPOSE:	Middlesex County Administration Middlesex County Improvement Authority Middlesex County Mosquito Commission Middlesex County Board of Social Services Middlesex County Utilities Authority Roosevelt Care Center
COBRA ADMINISTRATOR:	COBRA Elect P.O. Box 1839 Newark, NJ 07101-1839
PLAN AND CLAIMS SUPERVISOR:	Horizon Blue Cross Blue Shield of New Jersey 3 Penn Plaza East Newark, NJ 07105-2200
CLAIMS PROCESSING COMPANY:	Horizon Blue Cross Blue Shield of New Jersey
CONTRIBUTIONS:	**Medical Coverage:** Non-contributory for Active Employees and their eligible Dependents, unless otherwise determined by the Plan Participant's specific Local Unit. Non-contributory for Retired Employees (and eligible Dependents) who have retired on a disability pension, or have retired under the appropriate subsections of NJSA 40A:10-23 applicable to the Plan Participant's specific Local Unit. Contributory for Retired Employees (and Eligible Dependents) with years of services in a State of New Jersey administered Retirement system who fulfill the Eligibility Requirements of the Plan Sponsor.

Page updated September 2007

AVERAGE WORK WEEK REQUIREMENTS:	No less than twenty (20) hours, or based on individual collective bargaining unit agreements.
DEPENDENT CHILDREN'S COVERAGE:	**Medical Coverage:** From birth, unmarried Children to the last day of the Calendar Year in which the Dependent child attains the age of twenty-three (23).
RETIREE COVERAGE:	A Retired Employee who directly retires under the criteria of and participates in a State of New Jersey administered Retirement system and fulfill the Eligibility Requirements of the Plan Sponsor.
WAITING PERIOD:	Two (2) full months of Active Employment. Coverage commences the first day following completion of the waiting period.
STATUS/COVERAGE CHANGE DATE:	Date of change, unless otherwise indicated.
TERMINATION DATE:	See the following schedule.

SCHEDULE FOR TERMINATION OF MEDICAL COVERAGE

DATE OF TERMINATION	**DATE COVERAGE ENDS**
January 6 – February 5	March 1
February 6 – March 5	April 1
March 6 – April 5	May 1
April 6 – May 5	June 1
May 6 – June 5	July 1
June 6 – July 5	August 1
July 6 – August 5	September 1
August 6 – September 5	October 1
September 6 – October 5	November 1
October 6 – November 5	December 1
November 6 – December 5	January 1
December 6 – January 5	February 1

A more complete and detailed description of the coverage provisions and rights granted under this Plan are fully set forth in this Plan Document.

INTRODUCTION

This document is a description of the Middlesex County Joint Health Insurance Fund, Middlesex County Health Care Choice plan (Plan B) (this "Plan"). This Plan described is designed to protect eligible Plan Participants against catastrophic health expenses and provides certain health care benefits.

A person pays the expenses of day-to-day living. If a serious Sickness or Injury occurs, the cost involved could cause serious financial difficulties. This Plan can ease such financial burdens by providing reimbursement for the great majority of covered expenses.

Coverage under this Plan will take effect for an eligible Employee/Retiree and designated Dependent(s) when the Employee of such Dependent(s) satisfies the Waiting Period and all the Eligibility Requirements of this Plan.

The Fund and the Plan Sponsor fully intend to maintain this Plan indefinitely. ***However, the Plan Sponsor pursuant to the Fund By-Laws and in accordance with collective bargaining agreements, reserves the right to amend, suspend, discontinue or terminate this Plan upon advance notice to all Participants.***

Changes in this Plan may occur in any or all parts of this Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility guidelines and the like upon Fund approval.

Note that specific personnel policies may affect the provisions described in this Plan Document. Please contact your Personnel Department for more information.

This 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, even if expenses were incurred as a result of an accident, Injury or Sickness that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.***

If this Plan is terminated, the rights of Covered Persons are limited to coverage charges incurred before termination.

This document summarizes this Plan's rights and benefits for covered Employees/Retirees and their Dependent(s) and COBRA participants and is divided into the following parts:

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

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

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

Benefit Limits. Shows the limits applicable for certain conditions or treatment methods.

Cost Management Benefits. 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 this Plan are paid.***

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

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

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows this Plan's payment order when a person is covered under more than one (1) plan.

Third Party Recovery Provision (Subrogation). Explains this Plan's right to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

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

SECTION II
ELIGIBILITY
FUNDING
ENROLLMENT
TIMELY OR LATE ENROLLMENT
SPECIAL ENROLLMENT PERIOD
EFFECTIVE DATE
TERMINATION OF COVERAGE
OPEN ENROLLMENT

SECTION II

ELIGIBILITY

Coverage under this Plan is determined by whether the Employee/Retiree or Dependent is a member of an eligible class and completes the Waiting Period (as may be applicable):

Eligible Classes of Employees

The following person(s) are eligible classes of Employees ("Eligible Class(es)"):

(1) All Active Employees.

(2) All Elected and Appointed Officials (if applicable) who are sanctioned by the Public or County Entity.

(3) Retired Employees who directly retire under the criteria of and participates in a State of New Jersey **or Locally Administered** Retirement System.

Eligibility Requirements For Employee Coverage

A person is eligible for Employee coverage from the first day that (s)he:

(1) is considered to be an Active Employee of the Employer. An Employee is considered to be an Active Employee if (s)he normally works at least twenty (20) hours per week, or based on individual collective bargaining unit agreements, and is on the regular payroll of the Employer for that work;

(2) is in a class eligible for coverage;

(3) is an Active Employee under an in force collective bargaining agreement between the Plan Sponsor (Employer) and the collective bargaining unit(s);

(4) is a Retired Employee who directly retires under the criteria of and participates in a State of New Jersey **or Locally** Administered Retirement System; OR

(5) completes the employment Waiting Period as an Active Employee.

Medical Coverage

(a) Two (2) full months as an Active Employee. Coverage commences the first day following the completion of this Waiting Period.

A "Waiting Period" is the time between the first day of employment and the first day of coverage under this Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time, if any.

Eligible Classes of Dependents

A Dependent is eligible for coverage under this Plan as follows:

(1) A covered Employee's Spouse

Medical Coverage: The term "Spouse" shall mean the legally recognized marital partner of a covered Employee. Effective February 19, 2007, the term "spouse' shall also include a person who has established a civil union with a covered Employee pursuant to the provisions of the New Jersey Civil Union Act (P.L. 2006 Chapter 103). The Plan Administrator may require documentation proving a legal marital relationship or a civil union.

On or after February 19, 2007, wherever reference is in made in this Plan to "marriage', "husband", "wife", "family", "immediate family", 'dependent," "next of kin," or another word which in a specific context denotes a marital or spousal relationship, the same shall include a civil union pursuant to the provisions of the New Jersey Civil Union Act (P.L. 2006 Chapter 103).

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

Medical Coverage: Such children must be unmarried and be primarily dependent upon the covered Employee for support and maintenance. Coverage begins at birth and extends until the Dependent child marries or reaches the limiting age of twenty-three (23) years.

(a) Reaching the Limiting Age. Upon reaching the limiting age, coverage for:
(i) Medical benefits will terminate the last day of the Calendar Year.

(b) Marriage. Upon marriage, coverage for:
(i) Medical benefits will terminate on the last day of the Calendar Month in which the Dependent child marries.

The term "children" or "child" shall include natural children, step children, adopted children, foster children or children placed with a covered Employee in anticipation of adoption.

The phrase *"child placed with a covered Employee in anticipation of adoption"* refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption.

The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Coverage of these pre-adoptive children is required by the federal Omnibus Budget Reconciliation Act of 1993 and no Pre-Existing Conditions provisions, if any, are applied to this coverage. The child must be available for adoption and the legal process must have been commenced.

The phrase *"primarily dependent upon"* shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code.

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

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

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993, and no Pre-Existing Conditions provisions, if any, are applied to this coverage. This Plan's qualified medical child support order procedures are available upon request.

(3) **A covered Dependent child who is Totally Disabled.** A covered Dependent child who is incapable of self-sustaining employment by reason of mental illness, mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under this Plan when reaching the limiting age may be covered under this Plan beyond the limiting age. The Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two (2) year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at this Plan's expense, to determine the existence of such incapacity.

The following persons are excluded as Dependents

(1) Other individuals living in the covered Employee's home, but who are not eligible as defined.

(2) The legally separated or divorced former Spouse of the Employee.

(3) Any person who is on active duty in any military service of any country.

Eligibility Status Change

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.

Additional Eligibility Requirements for Dependent Coverage

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

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

If both husband and wife are Employees, and eligible for coverage under this Plan, both may enroll under this Plan and their children may be covered as Dependents of the husband and wife. Benefits will never exceed 100% of eligible covered charges.

Eligibility Requirements for Retired Employees and Other Medicare Eligible Persons

This Plan requires that Covered Persons who are eligible for Medicare (Retirees, disabled persons) must be enrolled under the full Medicare program (Part A/Medicare Hospital Insurance and Part B/Medicare Medical Insurance) in order to be a participant under this Plan. This Plan cannot pay for benefits which should be paid by Medicare.

Participants are required to enroll in Medicare Part A & Part B by the first of the month following thirty (30) days of the qualifying event if eligible for enrollment during Medicare Special Enrollment period, or during the next available Medicare Open Enrollment period (January 1st through March 31st of each year to be effective by the following July 1st) following the qualifying event.

A Retired Employee may remove otherwise eligible family members from this Plan at any time but may only add members within sixty (60) days of the change in family status (marriage, birth of a child, etc.). It is the Retired Employee's responsibility to notify the Employer of needed changes. If family members cease to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium) will not take place until the Retired Employee has formally requested that change. A Retired Employee may change plans no more than once in a twelve (12) month period or during a rate change period.

FUNDING

Cost of this Plan

Regarding Employee and Dependent Coverage: The Employer currently pays the entire cost of Active Employee and Dependent coverage under this Plan for those Employees who fulfill the Eligibility Requirements of this Plan set forth by the Plan Sponsor.

Regarding Retiree and Eligible Dependent Coverage: Retired Employees pay the full cost of coverage under this Plan in most cases. However, the former Employer may assume that cost if the Retired Employee meets certain requirements.

If the Retired Employee is paying the full cost of coverage, the monthly premiums will be billed to such Retired Employee on a monthly basis or as otherwise established by the Middlesex County Joint Health Insurance Fund. The Plan Sponsor has agreed to pay Retiree coverage if

(1) the Retiree receives benefits from a State of New Jersey **or Locally** Administered retirement system; and

(2) the Retiree has retired under appropriate subsections of NJSA 40A:10-23 applicable to the Employee's specific Local Unit; or

(3) (s)he retired on an approved Disability Retirement (regardless of year of service) in that retirement system.

Upon the death of the Retiree, the surviving spouse or eligible dependent may continue coverage, but must pay the full premium for the related coverage.

The level of Employee contributions, if any, is set by the Plan Sponsor. The Plan sponsor reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements

Coverage is contributory or non-contributory. A coverage is contributory when the Employee must pay all or part of its cost. An Employee must enroll for any coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also. If a Covered Employee already has Dependent coverage, a newborn child will be automatically covered from birth, however, a completed and signed enrollment application is required.

The Middlesex County Joint Health Insurance Fund offers several health care plans. If a person wishes to be enrolled, a person should complete the required enrollment form(s) and provide all information requested. It is important to select the proper coverage for one's family situation. If a person does not enroll all eligible Dependents, a person must wait until the next Open Enrollment Period (which could be as much as a year away) to do so.

A person must select one of the plans offered. If a person does not make a decision, there will be no coverage.

A Covered Person may remove otherwise eligible Dependents from this Plan at any time, but may only add eligible Dependents within sixty (60) days of the change in family status (for example: marriage, birth of a child, etc.). It is a Covered Person's responsibility to notify his or her Employer of additions, deletions, or changes which may have occurred which could affect eligibility and coverage. If an eligible Dependent ceases to be eligible, claims will not be paid. The actual change in coverage (and the corresponding change in premium, if any) will not take place until a person has formally requested the change.

Enrollment Requirements for Newborn Children

A newborn child of a covered Employee who has Dependent coverage is automatically covered, but must be enrolled in this Plan. Charges for covered nursery care will be applied to the Plan of the covered parent or covered newborn child.

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

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within sixty (60) days of the child's birth for coverage to take effect. However, newborn children shall be automatically covered from birth for thirty-one (31) days even if not enrolled within the required sixty (60) days, if the covered Employee also has

Dependent coverage. An enrollment application for the child must be completed to formally add the child as a Dependent.

If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment", there will be no payment from this Plan and the covered parent will be responsible for the cost.

TIMELY OR LATE ENROLLMENT

In order to enroll, an Employee must fill out and sign an enrollment application. An enrollment is either "timely" or "late":

(1) **Timely Enrollment.** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days, sixty (60) days for newborns, after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two (2) Employees (mother and father of the child(ren)) 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 during a Special Enrollment Period may join only during Open Enrollment.

The enrollment date for a Late Enrollee is the first day of coverage. Thus, the time between the date a Late Enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as a Waiting Period.

SPECIAL ENROLLMENT PERIOD

If an Employee is declining enrollment for himself/herself or his/her Dependents because of other health insurance coverage, the Employee may in the future be able to enroll himself/herself or his/her dependents in this Plan, provided that the Employee requests enrollment within 30 days after the other coverage ends.

In addition, if an Employee has new Dependents as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself/herself and his/her new Dependents, provided that the Employee requests enrollment within 30 days.

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 this Plan and the first day of coverage is not treated as a Waiting Period.

EFFECTIVE DATE

Effective Date of Employee Coverage

An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirements

(2) The Active Employee Requirement.

(3) The Enrollment Requirements.

(4) Completion of the Waiting Period.

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 this Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

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 COBRA Continuation Option):

(1) The date this Plan is terminated.

(2) The date the covered Employee's Employer ceases to be a covered Employer.

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

(4) The date the covered Employee 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 (1) month in any Calendar Year.

(5) **Medical Coverage:** The last day of the pay period or thirty (30) days following the last day of the Calendar Month in which the covered Employee ceases to be in one (1) of the Eligible Classes (see following schedule). This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)

Sample Schedule

DATE OF TERMINATION	DATE COVERAGE ENDS
January 6 – February 5	March 1
February 6 – March 5	April 1
March 6 – April 5	May 1
April 6 – May 5	June 1
May 6 – June 5	July 1
June 6 – July 5	August 1
July 6 – August 5	September 1
August 6 – September 5	October 1
September 6 – October 5	November 1
October 6 – November 5	December 1
November 6 – December 5	January 1
December 6 – January 5	February 1

Continuation During Periods of 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: the end of the three (3) calendar month period that next follows the month in which the person last worked as an Active Employee. Coverage will continue for an additional nine months if the required contribution, if any, is paid by the Employee.*

For leave of absence or layoff only: the end of the nine (9) calendar month period that next follows the month in which the person last worked as an Active Employee, if the required contribution, if any, is paid in advance by the Employee.*

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

***If coverage is extended under COBRA, the applicable COBRA period must include the continuation period.**

Continuation During Family and Medical Leave (FMLA)

Regardless of the established leave policies mentioned, 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 Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person was covered when the FMLA leave started, and will be reinstated to the same extent that it was in force when coverage terminated. For example, Pre-Existing Conditions Limitations and other Waiting Periods, if any, will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the 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 Re-employment Rights Act under the following circumstances. These rights apply only to Employees and their Dependants covered under this Plan before leaving for military services.

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

   (a) The eighteen (18) month period beginning on the date on which the Covered Person's absence begins; or

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

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

(3) A Plan Exclusion or Waiting Period, if any, may not be imposed in connection with the reinstatement of coverage upon the re-employment if one would not have been imposed had coverage not been terminated because of service. However, a Plan Exclusion or Waiting Period, if any, may be imposed for coverage of any Sickness or Injury, determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed (military) service.

When Dependent Coverage Terminates

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

(1) The date this Plan is terminated.

(2) The date that the Employee's coverage under this Plan terminates for any reason including death. (See the COBRA Continuation Option.)

(3) The date a covered Spouse loses coverage due to the loss of dependency status. (See the COBRA Continuation Option.)

(4) The date Dependent coverage is terminated under this Plan.

(5) On the first day of the month that follows the date that he or she ceases to be a Dependent as defined by this Plan. (See the COBRA Continuation Option.)

(6) The date the covered 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.

(7) **Regarding Dependent child(ren), whichever occurs first:**

Medical Coverage:

(a) The last day of the Calendar Month in which the Dependent marries, or

(b) The last day of the Calendar Year in which the Dependent attains age twenty-three (23).

NOTE: A "Certificate of Creditable Coverage" will be provided when coverage terminates and when necessary upon request. (Refer to Defined Terms for Creditable Coverage.)

Conversion Privilege

Employees, Retirees, and their 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-November, the annual Open Enrollment Period, covered Employees/Retirees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the Open Enrollment Period will become effective January 1st and remain in effect until the next January 1st unless:

(1) there is a change in family status during the year (birth, death, marriage, divorce, adoption); or

(2) the Employee or Spouse has taken a leave of absence or had a change in employment status; or

(3) termination of coverage due to loss of a Spouse's employment; or

(4) there has been a significant change in the Spouse's health insurance coverage.

To the extent previously satisfied, coverage Waiting Periods, if any, will be considered satisfied when changing from one plan to another during Open Enrollment. Plan Participants should contact their Personnel Department with regard to specific plan availability and eligibility. A Retired Employee may change plans no more than once in a twelve (12) month period or during a rate change period.

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.

SECTION III
HEALTH CARE CHOICE PLAN (PLAN B)
SCHEDULE OF BENEFITS

SECTION III

HEALTH CARE CHOICE PLAN (PLAN B)

SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBILITY 800-355-2583

Call this number to verify a Plan Participant's eligibility for Plan benefits before the medical charge is incurred.

MEDICAL BENEFITS

This Plan's Provisions include a Point of Service Health Care Choice Plan (POS) and access to the Horizon Blue Cross Blue Shield of New Jersey Provider Network. The Primary Network of Providers is considered and payable at the In-network benefit level. Because these Network Providers have agreed to charge reduced fees to persons covered under this Plan, this Plan can afford to reimburse a higher percentage of their fees.

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

The fee for services, care and treatment rendered by Network Providers is considered payable under this Plan's provisions based on per diem or pre-negotiated contracted rates.

Services provided by Non-network Providers is considered at the Out-of-network benefit level.

The fee for services, care and treatment rendered by Non-network Providers is considered payable under this Plan's provisions based on the Usual and Reasonable Charge.

Additional information about this option, as well as a list of Network Providers will be given to Plan Participants and updated as needed.

SELECTING A PRIMARY CARE PHYSICIAN

All of the care a Covered Person receives is managed by his or her Primary Care Physician. To insure maximum benefit when the Covered Person enrolls in the Health Care Choice Plan (POS) he or she should select a Primary Care Physician from the listing of Network Providers for himself or herself and any eligible Dependents. Each Dependent may select his or her own Primary Care Physician. The Covered Person may change his or her Primary Care Physician upon notice to the Plan Administrator.

Women may select two Primary Care Physicians-an Obstetrician/Gynecologist (OB/GYN) and General Practitioner. Once an OB/GYN has been selected, the Covered Person may contact the Physician directly for appointments.

The Primary Care Physician is committed to providing the best and most appropriate medical care. He or she should be the first contact for all health needs. Through the Primary Care Physician's

referral, a Covered Person will have access to the specialists and Hospitals associated with the Health Care Choice Plan (POS). A referral from the Primary Care Physician is not needed for OB/GYN services, Chiropractic Care, services rendered by a provider for Outpatient Mental Disorders/ Substance Abuse *(Drug and Alcohol Related)* Care, or for a routine eye exam.

To be eligible for In-network benefits (the maximum benefit available under this Plan), all services and supplies must be administered or referred by the Network Primary Care Physician. The only exception is for emergency care.

Additional information about this option, as well as a list of Network Provider will be given to covered Employees and updated as needed.

DEDUCTIBLES AND COPAYMENTS PAYABLE BY PLAN PARTICIPANTS

Deductibles and copayments are dollar amounts that the Covered Person must pay before this Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one (1) deductible amount per Plan and it must be paid before any money is paid by this Plan for any covered services. Each January 1st, a new deductible amount is required. Deductibles do not apply toward the satisfaction of the coinsurance out-of-pocket maximum.

A copayment is a smaller amount of money that is paid each time a particular service is used. Typically there may be copayments required on many services and other services will not have any copayments. Copayments do not apply toward the satisfaction of the coinsurance out-of pocket maximum.

COPAYMENTS

Copayments payable by Plan Participants

Network Providers:

Physician copayment, per office visit	$5
Emergency Services copayment *(Emergency Room/Center)* Medical Emergencies *(Accidental Injury, life/limb threatening)*	$25*(waived if admitted to Hospital)**
Medical Care copayment *(Emergency Room)* *(Non-emergency)*	$25 *(waived if admitted toHospital)**
Emergency Services copayment *(Other than Hospital)* Medical Emergencies *(Accidental Injury, life/limb threatening)*	$5 *(waived if admitted to Hospital)**

***Note: Precertification is required for Inpatient and Emergency admissions. Emergency services rendered In-network require that the Utilization Management Service must be notified within forty-eight (48) hours of the emergency treatment. The applicable copayment for these services is waived if admitted.**

DEDUCTIBLES

Deductibles payable by Plan Participants

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

Non-network Providers:

Covered Person deductible per Calendar Year	$100
Covered Family Unit deductible, per Calendar Year	$200 (cumulative)

COINSURANCE

Percentage payable by this Plan, per Calendar Year

Network Providers:

Inpatient Hospital care and services* *(General Conditions and Alcoholism)*	100%
Outpatient Hospital care and services* *(General Conditions and Alcoholism)*	100%
Inpatient Physician care and services *(General Conditions and Alcoholism*	100%
Physician care and services *(Office/Home)*	100% after applicable copayment
Physician charge for Ambulatory Surgery* *(Outpatient)*	100%
Inpatient Mental Disorders and Substance Abuse* *(Drug Related)*	100%
Inpatient Substance Abuse* *(Alcohol Related)*	100%
Outpatient Mental Disorders and Substance Abuse* *(Drug Related)*	100% after applicable copayment
Outpatient Substance Abuse *(Alcohol Related)*	100% after applicable copayment
Detoxification and Residential Facility*	100%

Emergency Services* *(Emergency Room/Center)*
Medical Emergencies *(Accidental Injury, life/limb threatening*
100% after applicable copayment*

Medical Care Emergency Room *(Non-emergency)* 100% after applicable copayment

***Note: Precertification is required for Inpatient and Emergency admissions. Emergency services rendered In-network require that the Primary Care Physician and/or Utilization Management Service must be notified within forty-eight (48) hours of the emergency treatment in order to receive maximum benefits at the In-network benefit level. The applicable copayment for these services is waived if admitted.**

Out-of-Area Emergency Services* *(Emergency Room/Center)*
Medical Emergencies *(Accidental Injury, life/limb threatening)*
100% after applicable copayment*

Medical Care Emergency Room *(Non-emergency)* 100% after applicable copayment*

***Note: Emergency services rendered out of the area require that the Utilization Management Service must be notified within forty-eight (48) hours of the emergency treatment in order to receive maximum benefits. The applicable copayment for these services is waived if admitted.**

Percentage Payable by this Plan, per Calendar Year

Non-network Providers:

Inpatient Hospital care and services *(General Conditions and Alcoholism)*	80% after deductible
Outpatient Hospital care and services *(General Conditions and Alcoholism)*	80% after deductible
Inpatient Physician care and services *(General Conditions and Alcoholism)*	80% after deductible
Physician care and services *(Office/Home)*	80% after deductible
Physician charge for Ambulatory Surgery* (*Outpatient*)	80% after deductible
Inpatient Mental Disorders and Substance Abuse* *(Drug Related)*	80% after deductible
Inpatient Substance Abuse* *(Alcohol Related)*	80% after deductible
Outpatient Mental Disorders and Substance Abuse* *(Drug Related)*	80% after deductible

Outpatient Substance Abuse *(Alcohol Related)*	80% after deductible
Detoxification and Residential Facility*	80% after deductible
Emergency Services* *(Emergency Room/Center)*	
Medical Emergencies *(Accidental Injury, life/limb threatening)*	80% after deductible*
Medical Care Emergency Room *(non-emergency)*	80% after deductible
Out-of-Area Emergency Services* *(Emergency Room/Center)*	
Medical Emergencies *(Accidental Injury, life/limb threatening)*	80% after deductible*
Medical Care Emergency Room *(Non-emergency)*	80% after deductible*

***Note: Precertification is required for Inpatient and Emergency admissions. Emergency services rendered Out-of-Network require that the Utilization Management Service must be notified within forty-eight (48) hours of the emergency treatment in order to receive maximum benefits at the In-network benefit level.**

Maximum out-of-pocket payments, per Calendar Year, excluding deductible

This Plan will pay the percentage of covered charges designated above until the following amounts of out-of-pocket payments (coinsurance) are reached, at which time this Plan will pay 100% of the remainder of covered charges, for eligible Covered Persons for the balance of that Calendar Year unless stated otherwise.

Network Providers:	
Per Covered Person	$300
Per Covered Family Unit	$600 (cumulative)
Non-network Providers:	
Per Covered Person	$400
Per Family Unit	$800 (cumulative)

MAXIMUM BENEFIT AMOUNTS

Lifetime, while covered:	
In-Network	Unlimited
Out-of-Network	$1,000,000

There are other maximums on individual benefits. These follow under **Benefits and Benefit Limits.**

BENEFITS AND BENEFIT LIMITS

Hospital Daily Room and Board *(Precertification required)*

Payment Rate	the average semiprivate room rate; or pre-negotiated contracted rate
Inpatient Calendar Year maximum	three hundred sixty five (365) days for General Conditions and Alcoholism

Note: Refer to Mental Disorders/Substance abuse *(Drug Related)* for other provisions.

Intensive Care/Coronary Care/Neonatal/Burn Unit *(Precertification required)*

Daily limit	Hospital's ICU/CCU/NCU charge; or pre-negotiated contracted rate

Preadmission Testing

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan).

Physician Services

Inpatient visits percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Physician/Specialist home/office visits

Percentage payable:	
Network Providers	100% after applicable copayment
Non-network Providers	80% after deductible

Inpatient surgical *(Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Outpatient surgical *(Ambulatory) (Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Spinal Manipulation/Chiropractic Care*

Percentage payable:	
Network Providers	100% after applicable copayment
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical Necessity and Appropriateness of continued care. Care which is considered maintenance is not covered.**

Second Surgical Opinion *(Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Anesthesia

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan).

Assistant Surgeon *(Payment based on a percentage of the surgeon's fee)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Maternity Care/Pregnancy *(Precertification required)*

Percentage payable:	
Network Providers	100% after applicable copayment for initial visit only
Non-network Providers	80% after deductible

Nursery Facility Charges *(Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Well Newborn Nursery Care *(Physician)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Associated Medical Services
(Diagnostic X-rays, Therapeutic X-rays, Laboratory & Pathology Tests, Diagnostic Testing, Chemotherapy & Radiation Therapy)

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Home Health Care *(Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Four (4) hours equal	One (1) visit
Calendar Year maximum	Unlimited visits

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan)

Home Dialysis *(Precertification required)*

Percentage payable:	
Network Providers	100% when services are provided and billed by a Network Hospital or Freestanding Dialysis Center
Non-network Providers	80% after deductible

Surgical Center *(Admission and discharge within twenty-four (24) hours)*
(Precertification required)

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Birthing Center *(Precertification required)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Hospice Care *(Precertification and Case Management required)*

Outpatient Physician visit	100% after applicable copayment
Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Lifetime Maximum	Two hundred ten (210) days

Skilled Nursing Facility & Rehabilitation Facility *(Precertification required)*

Covered daily charge limit	The Facility's Usual and Reasonable Charge; or pre-negotiated contracted rate
Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Calendar Year maximum:	
Network Providers	One Hundred (100) days
Non-network Providers	Sixty (60) days

Note: Total maximum days for both Network and Non-network Providers is not to exceed one hundred (100) days.

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Ambulance Service *(Hospital billed)*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Speech Therapy*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical Necessity and Appropriateness of continued care.**

Occupational Therapy*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical necessity and Appropriateness of continued care.**

Physical Therapy*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical necessity and Appropriateness of continued care.**

Cardiac Rehabilitation Therapy*

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical necessity and Appropriateness of continued care.**

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Other Therapy Services *

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

***Note: A medical review of the treatment plan is required periodically to determine Medical necessity and Appropriateness of continued care.**

Outpatient Private Duty Nursing

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Hair/Scalp Prosthesis

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Maximum benefit, per Twenty-four (24) months	$500

Dental Prosthesis

Percentage payable within twelve (12) Months of an accidental Injury:	
Network Providers	100%
Non-network Providers	80% after deductible

Durable Medical Equipment (DME) ***(Precertification required on large DME)***

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Medical/Surgical Supplies

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Prosthetics/Orthotics

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Jaw Joint/TMJ (Prior authorization and review of Treatment Plan required)

Percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Mental Disorders and Substance Abuse (*Drug Related*) Treatment Limits
(*Precertification required for Inpatient only)*

Inpatient percentage payable:	
Network Providers	Twenty-five (25) days per Calendar Year covered at 100%; balance at 90% and subject to the Annual/ Lifetime maximums
Non-network Providers	80% after deductible and subject to the Annual/Lifetime maximums

Inpatient Physician care percentage payable**:**	
Network Providers	Twenty-five (25) days per Calendar Year covered at 100%; balance at 90% and subject to the Annual/ Lifetime maximums
Non-network Providers	80% after deductible and subject to the Annual/Lifetime maximums

Partial Hospitalization (*Day Care*)*

Percentage payable:	
Network Providers	Balance of remaining inpatient days at 100% and subject to the Annual/ Lifetime maximums
Non-network Providers	Balance of remaining inpatient days at 80% after deductible and subject to the Annual/Lifetime maximums

***Note: Unused inpatient days may be exchanged for Partial Hospitalization visits on a two-for-one basis. (One (1) inpatient day equals two (2) Partial Hospitalization visits). Day Care is care in an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period.**

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Outpatient percentage payable:	
Network Providers	100% after applicable copayment
Non-network Providers	80% after deductible
Inpatient and Outpatient*	
Calendar Year (Annual) maximum	Inpatient days plus $15,000
Inpatient and Outpatient*	
Lifetime maximum	Inpatient days plus $50,000

***Note: This is a total combined maximum for Mental Disorders and Substance Abuse (*Drug Related*).**

***Note: This Plan contains an unique automatic restoration provision which can restore benefits issued for Mental Disorders. This provision is applicable in the Calendar Year immediately following the initial Calendar Year in which benefits are paid for Mental Disorders. The patient must be a Covered Person at the beginning of the year the restoration begins. The maximum that may be restored in a Calendar Year is $2,000. The amount restored will be the lessor of $2,000 or the amount that will bring the total lifetime benefit to $50,000. A maximum restoration of $50,000 is available for the lifetime of the patient.**

Alcoholism Treatment Limits (*Precertification required for Inpatient only)*

Inpatient percentage payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Outpatient percentage payable:	
Network Providers	100% after applicable copayment
Non-network Providers	80% after deductible
Lifetime maximum	Part of the Plan maximum

Detoxification and Residential Facility (*Precertification required*)

Percentage Payable:	
Network Providers	100%
Non-network Providers	80% after deductible

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Organ Transplant Coverage Limits (*Precertification and prior authorization required)*
Covered Transplant Procedures:

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational".

Percentage Payable:	
Network Providers	100%
Non-network Providers	80% after deductible
Transplant Lifetime maximum Benefit	Part of the Plan Maximum
Donor coverage maximum	Covered under the Transplant Lifetime Maximum

Note: Transportation and storage costs directly related to the donation of the organ and billed by the Hospital are covered under this Plan.

This Plan covers a Covered Person's charges as a donor only when the recipient is also a Covered Person.

Preventive Care *(Routine Well Adult Care)*

Percentage payable:	
Network Providers	100% after applicable Copayment
Non-network Providers	**NOT COVERED**

Coverage includes reimbursement for the following routine services: pap smear, mammography, prostate screening, gynecological and routine physical examination, related x-rays, laboratory tests, hearing screening and immunizations.

Routine Well Adult Care Limits
Frequency limitations:

Frequency limits for pap smear	One (1) per Calendar Year
Frequency limits for mammography	Ages thirty-five (35) through thirty-Nine (39): *One (1) single Baseline Mammography* Ages forty (40) through forty-nine (49): *One (1) every two (2) years* Age 50 and over: *One (1) annually*
Frequency limits for prostate screening	Ages forty (40) and over with family history: *One (1) annually* Age 50 and over: *One (1) annually*

Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)

Preventive Care *(Routine Well Child Care)*

Percentage payable:	
Network Providers	100% after applicable copayment*
Non-network Providers	80% after deductible**

***Note: In-network coverage includes payment for the following routine services: routine physical examinations, related x-rays, laboratory tests and immunizations.**

****Note: Out-of-network coverage includes payment for the following routine services: injections, immunizations, diagnostic x-rays, laboratory tests and other testing, physical and speech therapy for covered Dependent children less than twelve (12) months of age. No coverage is provided for periodic physical exams, immunizations or other routine preventive and wellcare services for Covered Persons over twelve (12) months of age.**

Vision Screening

Percentage payable:	
Network and Non-network Providers	100%; deductible waived
Calendar Year maximum	$50*

***Note: Services and benefits are limited to an examination, frames and lenses and are subject to the Calendar Year maximum in total expenses.**

Prescription Drugs

A Standalone Prescription Drug Card Plan's copayments per prescription filled or refilled are eligible for reimbursement under this Medical Plan.

Prescription drugs and medications are only eligible under this Medical Plan when prescribed by a licensed Physician and dispensed by a licensed Pharmacists when Medically Necessary to treat a medical condition and not payable under the Prescription Drug Card Plan.

Percentage Payable:	
Network and Non-network Pharmacy:	80% after deductible

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE: Per Calendar Year**	• Per Covered Person	NONE	$100**
	Per Covered Family Unit (cumulative)	NONE	$200**
COVERAGE & COINSURANCE	• Plan pays	100%; or 90% where applicable	80% of $2,000; then 100%
	• Covered Person pays	Applicable Copayment; or 10% where applicable	20% of $2,000
OUT OF POCKET MAXIMUM Per Calendar Year	• Per Covered Person • Per Covered Family Unit (cumulative) EXCLUDING DEDUCTIBLES where applicable	When annual coinsurance payments (out-of-pocket) equals $300 per Covered Individual / $600 per Covered Family Unit, then the 100% benefit provision will apply for all eligible covered expenses for all eligible Covered Persons in the Covered Family Unit for the balance of that Calendar Year	When annual coinsurance payments (out-of-pocket) equals $400 per Covered Individual / $800 per Covered Family Unit, then the 100% benefit provision will apply for all eligible covered expenses for all eligible Covered Persons in the Covered Family Unit for the balance of that Calendar Year
INDIVIDUAL LIFETIME MAXIMUM	• Per Covered Person	Unlimited	$1,000,000

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE **See #NOTE below** ***** NOT COVERED or Limited for Out-of-Network Benefits	• **Adult Routine Physical Exams* and Including** • Related X-ray/ Laboratory tests* • Well Woman Exam* • Pap Smear*# • Mammography*# • Immunizations* • Prostate Screening* • Hearing Screening* • **Well Child Care* Including** • Routine Physicals* • Related X-ray Laboratory tests • Immunizations*	$5 Copayment; then 100% Coverage	NOT COVERED Deductibles apply** 80% Coverage; 20% Coinsurance are provided for injections, immunizations, diagnostic x-ray/ laboratory, physical therapy, speech therapy for children not less than twelve (12) months old. No coverage is provided for periodic physical exams, pap smears, immunizations or well care for Covered Persons over twelve (12) months old.
PHYSICIAN SERVICES	• Inpatient Visits • Surgical Services @ • Anesthesia • Assistant Surgeon • Nursery, Well Newborn Care • Physicians/Specialist • Home/Office Visits • Chiropractic Visits and other Services • Periodic review of Treatment Plan and medical care required to determine Medical Necessity and • Appropriateness of continued care	100% Coverage $5 Copayment; then 100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance Deductibles apply** 80% Coverage; 20% Coinsurance

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations and Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Person per Calendar Year (cumulative)

#NOTE: Preventive Care – the following is limited to:
Routine Pap Smear: one (1) per Calendar Year
Mammography: Ages 35-39: *one (1) baseline*
Ages 40-49: *one (1) every two (2) years*
Ages 50 & over: *one (1) annually*
Prostate Screening: Age 40 & over with family history: *one (1) annually*
Age 50 & over: *one (1) annually*

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" are not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
ASSOCIATED MEDICAL SERVICES Professional / Facility Services	• Diagnostic X-ray • MRIs & Cat Scans • Therapeutic X-ray • Laboratory Tests & Pathology • Chemotherapy & Radium/Radon Therapy • Diagnostic Screening Tests • Mammography Screening (diagnosed)	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
SECOND SURGICAL OPINION@	• Physician other than one performing the surgical procedure	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
MATERNITY/ PREGNANCY@	• Treated the same as any other Sickness	$5 Copayment initial visit only; then 100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
HOSPITAL INPATIENT@ • General Conditions • Alcoholism	• Unlimited Days Semi-Private Room/Board • Other Hospital provided Services, Facilities, Supplies, & Equipment • Intensive Care/ Coronary Care/ Neonatal	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
ORGAN TRANSPLANTS@	• Medically Necessary • Non-Experimental	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
HOSPITAL OUTPATIENT	• Ambulatory Surgery @ (includes Surgery Center Confinement) • Surgery @ • Pre-admission Testing • Chemotherapy & Radiation Therapy and Other Therapy Services • Blood • Diagnostic X-rays • Laboratory Tests • Ambulance (Hospital billed) • Dialysis @	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT MENTAL DISORDERS & SUBSTANCE ABUSE SERVICES (*Drug Related) @* • **IMPORTANT**: Partial Hospitalization (*Day Care*) must be pre-authorized. Unused Inpatient Days may be exchanged for Partial Hospitalization Visits on a two-for-one basis. (One (1) Inpatient Day equals two (2) Partial Hospitalization Visits).	• Day limits per Calendar Year @ 100% • Combined totals for In- & Out-of-Network with Substance Abuse (*Drug Related*)* • Combined Inpatient & Outpatient, In & Out-of-Network for Calendar Year and Lifetime Maximums* • Day Care is an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period	Twenty-five (25) Days at 100%; balance at 90% Coverage; 10% Coinsurance; and subject to the Annual & Lifetime Maximums*	Deductibles apply** 80% Coverage; 20% Coinsurance; and subject to the Annual & Lifetime Maximums*
INPATIENT SUBSTANCE ABUSE (Alcoholism Only)	• All Hospital provided services covered on the same basis as any other medical condition	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
MENTAL DISORDERS & SUBSTANCE ABUSE (*Drug Related)@* • Related Care in an Intermediate Care Facility • **IMPORTANT:** Partial Hospitalization (*Day Care*) must be pre-authorized. Unused In-patient Days may be exchanged for Partial Hospitalization Visits on a two-for-one basis. (One (1) Inpatient Day equals two (2) Partial Hospitalization Visits).	• See Inpatient for provisions and limitations	Twenty-five (25) Days Covered at 100%; balance at 90% Coverage; 10% Coinsurance; and subject to the Annual & Lifetime Maximums*	Deductibles apply** 80% Coverage; 20% Coinsurance; and subject to the Annual & Lifetime Maximums*
DETOXIFICATION & REHABILITATION FACILITY@	• Inpatient individual and group therapy • Family counseling for Inpatient	100% Coverage; no additional charge to member	Deductibles apply** 80% Coverage; 20% Coinsurance

SUBSTANCE ABUSE (*Alcohol Related***)@** In an Intermediate Care Facility	• Covered on the same basis as any other medical condition	100% Coverage; no additional charge to member	Deductibles apply** 80% Coverage; 20% Coinsurance

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT MENTAL ISORDERS & SUBSTANCE ABUSE (*Drug Related*)	• Copayment applies per Visit • Combined with Inpatient for Calendar Year Maximums*	$5 Copayment; then 100% Coverage Annual & Lifetime Maximums Apply*	Deductibles apply** 80% Coverage; 20% Coinsurance Annual & Lifetime Maximums Apply*
OUTPATIENT SUBSTANCE ABUSE (*Alcohol Related)*	• Copayment applies per Visit • Covered on the same basis as any other medical condition	$5 Copayment; then 100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
MAXIMUM BENEFITS MENTAL DISORDERS & SUBSTANCE ABUSE (*Drug Related*)	• Combined Maximum Benefit In & Outpatient, In & Out-of-Network* • Per Calendar Year and Lifetime*	• Inpatient Days plus • $15,000 per Calendar Year* • $50,000 Lifetime*	
AMBULANCE	• Ground	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
OUTPATIENT SHORT-TERM REHABILITATION	• Physical Therapy • Speech Therapy • Occupational Therapy • Cardiac Rehabilitation Therapy • Other Therapy Services • A review of the Treatment Plan and medical care is required periodically to determine Medical Necessity and Appropriateness of continued care	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
EMERGENCY SERVICES@ • For use of Emergency Facility/Copayment will apply • Copayment waived if admitted • Utilization Management Service notification and authorization required within forty eight (48) hours of the emergency treatment for In or Out-of-network or Out of the area services rendered to continue In-Network Benefits and/or received maximum Benefits	• In-Network benefits apply to all services for first forty-eight (48) hours for the following: ° Accidental Injury ° Sudden & Serious Medical Condition (life threatening)	$25 Copayment for emergency room only; $5 Copayment for all other facilities or places of service; then 100% Coverage	$20 Copayment; then 100% Coverage In-Network Benefits will apply when the Utilization Management Service is notified within forty-eight (48) hours of the emergency treatment; otherwise Deductibles Apply** 80% Coverage; 20% Coinsurance

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY SERVICES **Emergency Room only**	• Medical Condition • (Non-emergency or admission)	$25 Copayment for emergency room only; $5 Copayment for all other facilities or places of service; then 100% Coverage	$25 Copayment; then 100% Coverage In-Network Benefits will apply when the Utilization Management Service is notified within forty-eight (48) hours; otherwise Deductibles Apply** 80% Coverage; 20% Coinsurance
HOME HEALTH CARE	• Treatment Plan prescribed by the attending Physician • Medically Necessary • Following or in lieu of hospitalization or facility stay • Four (4) hours equal one (1) Visit	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
SKILLED NURSING & REHABILITATION FACILITY@ • Total Maximum Days will not exceed one hundred (100) Days	• Medically Necessary • Confinement following Hospital confinement or in lieu of Hospital stay • In-Network one hundred (100) Days per Calendar Year* • Out-of-Network sixty (60) Days per Calendar Year* • Combined Maximum Benefits In & Out-of-Network per Calendar Year	100% Coverage Maximum Benefit Applies* One Hundred (100) Days per Calendar Year	Deductibles apply** 80% Coverage; 20% Coinsurance Maximum Benefit Applies* Sixty (60) Days per Calendar Year
OUTPATIENT PRIVATE DUTY NURSING CARE	• Medically Necessary • Prescribed by the attending Physician	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
BIRTHING CENTERS@ **Facility Services**	• Refer to Physician Services for Physician benefits under this Plan	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
SURGICAL CENTER@ **Ambulatory Surgical Center Facility Service (where applicable)**	• Admission and discharge within twenty four (24) hours • Refer to Physician Services for Physician benefits under this Plan	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance

HOSPICE	• Copayment per Physician's visit only • Up to Two hundred ten (210) Days per Lifetime	$5 Copayment for Physician Visit only; all other services 100% Coverage Maximum Benefit Applies*	Deductibles apply** 80% Coverage; 20% Coinsurance Maximum Benefit Applies*

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**
**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

BENEFIT SUMMARY – HEALTH CARE CHOICE PLAN (PLAN B)
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
PROSTHETIC & ORTHOTIC APPLIANCES	• Medically Necessary • Scalp/Hair Prosthesis $500 Maximum in a twenty-four (24) month period (See covered charges for limitations) • Dental within twelve (12) months of an accidental Injury • Breast Prosthesis following Reconstructive Surgery	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
DURABLE MEDICAL EQUIPMENT (DME)	• Medically Necessary • Prior authorization is required by the Utilization Management Service for Large Durable Medical Equipment (DME)	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
MEDICAL/SURGICAL SUPPLIES	• Medically Necessary • Prescribed by the attending Physician	100% Coverage	Deductibles apply** 80% Coverage; 20% Coinsurance
PRESCRIPTION DRUGS	• Prescribed by a Physician and dispensed by a licensed Pharmacist to treat a Medical Condition • Not payable under a Prescription Card Plan, but an eligible drug / medication supply under this Plan and Medically Necessary • A Standalone Prescription Drug Card Plan copayment is eligible for reimbursement under this Medical Plan	Deductibles apply** 80% Coverage; 20% Coinsurance	

NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.

* **All Limitations & Maximum totals are combined In and Out-of-Network unless otherwise noted.**

**** Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

NOTE: Alcoholism is covered on the same basis as any other medical condition.

@ Certification Required – Non Compliance Penalty – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

VISION BENEFIT	
• Vision Examination • Lenses, Frames or Contacts	$50 per Covered Person per Calendar Year

SECTION IV
HEALTH CARE CHOICE PLAN (PLAN B)
MEDICAL BENEFITS
COST MANAGEMENT BENEFITS
INPATIENT PRE-ADMISSION CERTIFICATION REQUIREMENT
CONCURRENT STAY REVIEW/DISCHARGE PLANNING
EMERGENCY SERVICES
OUT OF THE AREA EMERGENCY CARE SERVICES
SURGICAL PROCEDURES & SECOND OPINIONS
SECOND SURGICAL REVIEW LIST
HIGH RISK MATERNITY REVIEW PROGRAM
LARGE CASE MANAGEMENT
PLAN EXCLUSIONS

SECTION IV

HEALTH CARE CHOICE PLAN (PLAN B)

MEDICAL BENEFITS

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

DEDUCTIBLE

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

This amount will not apply toward the satisfaction of the coinsurance out-of-pocket maximum payment.

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

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

Deductible Three (3) Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Deductible For A Common Accident. This provision applies when two (2) or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident, instead; only one (1) deductible will be required for them as a unit.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or the "Benefit Limits" of this Plan.

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 this Plan for all covered charges incurred by a Covered Person.

OUT-OF-POCKET LIMIT

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

When a Family Unit reaches the out-of-pocket limit, covered charges for that Family Unit will be payable at 100%, if applicable to this Plan, (except for the charges excluded, if any) for the remainder of that Calendar Year.

COVERED CHARGES

Covered charges are the fees that are incurred for the following items of service and supply. These charges or fees are subject to the Usual and Reasonable Charges or pre-negotiated contracted rates and the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **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.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate. The Covered Person will be requiring to pay the difference.

Charges for an Intensive Care/Coronary Care, Neonatal or Burn Unit stay are payable as described in the Schedule of Benefits.

Birthing Center charges covered by this Plan are pre-natal care, delivery and post partum care in connection with a Covered Person (including a covered Dependent daughter).

Charges for all other Medically Necessary services and supplies during confinement are covered.

(2) **Emergency Care – In and Out of the Service Area**. Under the Health Care Choice Plan, a Covered Person is covered for medical emergencies both inside and outside the Provider Network service area (the geographic area within which health care services are provided by the Provider Network). A Medical Emergency is generally defined as a Sickness or Injury of such a nature that failure to get immediate health care could put a person's life in danger or cause serious harm to bodily functions. Some examples of medical emergencies are: apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries. Unless the condition requires immediate care, the Covered Person should avoid the emergency room and contact the Primary Care Physician's office. The Utilization

Management Service, Primary Care Physician (or covering Physician) can be reached twenty-four (24) hours a day.

It notification prior to treatment is not reasonably possible, the Covered Person should seek treatment at the nearest emergency facility. All such treatment received during the first forty-eight (48) hours after the onset of the Medical Emergency will be eligible for In-network benefits, regardless of whether such treatment is received in or out of the service area, or whether such treatment is furnished by a Network Provider, The Covered Person must notify the Utilization Management Service and/or Primary Care Physician of the Medical Emergency within those first forty-eight (48) hours, and receive authorization for the continuation of any necessary medical services, in order for any such treatment received after those first forty-eight (48) hours to continue being eligible for In-network benefits.

For all medical emergencies, present the Health Care Choice Plan identification card to the Hospital representatives at the time of treatment. The card contains all necessary emergency instructions. The emergency facility may verify coverage.

(3) **Hospital Outpatient Care**. Hospital-billed services and supplies are:

(a) Accidental Injury.

(b) Surgery of a cutting or cauterizing nature (except for chemical cauterization).

(c) Surgical diagnostic procedures performed in a Hospital outpatient department (instead of a Physician's office or some other facility).

(d) Blood transfusions.

(e) Application of plaster casts/fiberglass.

(f) Complete cardiac pacemaker follow-up examinations.

(g) Dialysis treatment.

(h) Removal of implanted orthopedic hardware.

(i) Alcohol services.

(j) Poisoning treatment.

(k) Additional services billed by the Hospital.

Benefit for outpatient diagnostic services.

(a) Radiology, ultrasound and nuclear medicine.

(b) Laboratory and pathology.

(c) ECG, EEG, and other diagnostic medical and physiological medical testing procedures.

Benefits for outpatient emergency accident care and emergency medical care.

(a) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within forty-eight (48) hours of the accident.

(b) Care for the initial treatment of a Medical Emergency within forty-eight (48) hours of the onset of the Medical Emergency.

Benefits for outpatient surgical care.

Benefits for outpatient therapy services after an Injury or Sickness.

(a) Radiation therapy.

(b) Chemotherapy.

(c) Dialysis.

(d) Physical therapy.

(e) Respiration therapy.

(f) Any Medically Necessary therapy prescribed and performed on an outpatient basis.

(4) **Physician Care**. The professional services of a Physician for surgical or medical services.

The fee for a surgical procedure is the fee of the surgeon and/or assistant surgeon. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's Usual and Reasonable Allowance or pre-negotiated contracted rate.

(5) **Surgical Charges**. A surgical charge is the fee for performing a surgical procedure. It may be the fee of the surgeon, and/or the assistant surgeon. Also, reconstructive surgical procedures for a Sickness or Injury or for a functional birth defect in a Covered Dependent child.

(6) **Assistant Surgeon**. The Maximum Payment for all assistant surgeons for each surgical procedure is up to 25% of the fee of the surgeon's fee.

(7) **In the Hospital Physician Care**. This benefit applies when a medical charge is incurred for the care of a Covered Person's Injury or Sickness during a Hospital confinement that starts while the person is covered for those benefits.

A medical charge is the fee of a Physician for medical care performed while the Covered Person is Hospital confined. However, a medical charge will not include:

(a) a charge for care not rendered in the presence of a Physician; or

(b) a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

(8) **Diagnostic Testing, X-Ray, Pathology and Laboratory Charges**. Diagnostic testing, x-ray, pathology and laboratory charges are the fees for x-rays, pathology and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

(a) Diagnostic x-ray services, including MRI's and Cat Scans.

(b) Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician.

(c) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician.

(d) Allergy testing when performed and billed for by a Physician.

Charges for the following will not be included under this provision; however, these services may be covered under other provisions of this Plan:

(a) premarital exams;

(b) routine physical exams/and related services unless otherwise stated in the Schedule of Benefits;

(c) x-ray therapy or chemotherapy; or

(d) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

(9) **Radiation Charges and Limits**. A radiation charge is the fee of a Physician for x-ray, radium or radiotherapy treatment.

Radiation charges will not include charges for diagnostic or cosmetic procedures or the purchase or rental of radioactive substances.

(10) **Chemotherapy Charges and Limits**. A chemotherapy charge is the fee of a Physician for chemotherapy for malignant diseases.

The type of drug for which benefits are provided is limited to antineoplastic agents that are not in an Investigational or Experimental stage.

(11) **Accident Charge Benefits**. This benefit applies when an accident charge is incurred for care and treatment rendered in the Hospital emergency room/outpatient department for a Covered Person's Injury and:

(a) The Injury is sustained while the person is covered for these benefits; and

(b) the charge is for a service delivered within forty-eight (48) hours of the date of the accident; and

(c) to the extent that the charge is not payable under any other benefits under this Plan (other than Medical Benefits).

Benefits will be paid as described in the Schedule of Benefits.

An accident charge is a fee incurred for the following:

(a) Physician services.

(b) Hospital care and treatment.

(c) Diagnostic x-rays and laboratory tests.

(d) Local professional ambulance service.

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

(f) Nursing service.

(g) Anesthesia.

(h) Covered prescription drugs.

(12) **Second Opinion Consulting Services**. This Plan provides benefits for a second Physician's personal examination of a patient following a prior Physician's recommendation for elective surgery. The elective surgery must require the patient to be a bed patient in a Hospital. It must be recommended by a Physician other than the one performing the surgery, for example a Doctor of Medicine on a Doctor of Osteopathy. This Plan will pay for one (1) consultation by a qualified specialist Physician.

When the second Physician does not confirm the need for surgery, this Plan will pay for one (1) additional consultation if the patient asks for it. This Plan will also pay for any diagnostic x-rays, laboratory tests or diagnostic surgical procedures required by the Physicians performing the consultations. This Plan will make this payment for diagnostic services even

if they would not otherwise be eligible under this Plan. This Plan will pay for all consultation and diagnostic services in full.

To be covered, second opinion consultation services also must meet the following conditions:

- The surgery must be elective. This means that it cannot be an emergency or a life-threatening condition. It also means that the surgery can be at the convenience of the Physician or patient.

- The consultation services must be performed before the patient is admitted to the Hospital for the recommended surgery.

  If the Physician providing a second (or third) opinion consultation also performs the surgery, this Plan will not pay for the consultation with the consultant who also performs the surgery.

(13) **Skilled Nursing Facility Care**. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable as shown in the Schedule of Benefits if and when:

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

(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.

(14) **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.

(15) **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 care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. The Home Health Care Plan must be in writing and provided by the attending Physician before care begins and be reviewed by the attending Physician at least once every thirty (30) days.

Services, care and treatment rendered in the Covered Person/patient's home for the treatment of Lyme Disease include, but are limited to, a licensed home infusion company, a Registered

Nurse (R.N.), medication and medical supplies prescribed by the attending Physician. Following the initial phase of treatment, continued care and treatment requires medical review for Medical Necessity and approval of proposed treatment.

When home health care can take the place of inpatient care, this Plan covers such care furnished to a Covered Person under a written home health care plan. Medically Necessary services or supplies, when eligible under this provision are: (a) routine nursing care (furnished by or under the supervision of a Registered Nurse); (b) physical therapy; (c) occupational therapy; (d) medical social work; (e) nutrition services; (f) speech therapy; (g) home health aide services; (h) medical appliances and equipment, drugs and medications, laboratory services and special meals; and (i) any diagnostic or therapeutic service, including services performed in a Hospital outpatient department, a Physician's office or any other licensed heath care facility, provided such service would have been covered under this Plan if performed as inpatient Hospital services.

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 (4) hours of home health aide services.

(16) **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 (6) months and placed the person under a Hospice Care Plan.

A Hospice Care Plan includes services and supplies including prescription drugs, to the extent they are otherwise covered by this Plan. Services and supplies may be furnished on an inpatient and outpatient basis.

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

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

(b) **Rental of durable medical or surgical equipment** if deemed Medically Necessary. Durable Medical Equipment is (i) primarily and customarily used for medical purposes and is not generally useful in the absence of Sickness or Injury; (ii) can effectively be used in a non-medical facility (home); (iii) be expected to make a significant contribution to the treatment of Sickness or Injury; (iv) is used solely for the care and treatment of the patient; and (v) the cost of the equipment is proportionate to the therapeutic benefits which can be derived from the use of the equipment.

(c) **Medically necessary land or air ambulance/transportation service**. Transportation to or from a treatment center to receive Medically Necessary treatment is not covered; unless, the transportation is Medically Necessary (i.e. an

emergency) and the service is to the nearest Hospital or Skilled Nursing Facility where the treatment can be provided.

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

(e) The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** which replace body parts provided that the loss occurred while covered under this Plan.

(f) The initial purchase, fitting, repair and replacement of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness that occurred while covered under this Plan.

(g) **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 to improve a body function.

(h) Therapy that is by a qualified **speech therapist** as described in (i) and (ii):

(i) speech therapy to restore speech after a loss or impairment of a demonstrated previous ability to speak. To qualify under (i), the loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. Examples of non-covered therapy are therapy to correct pre-speech deficiencies and therapy to improve speech skills that have not fully developed;

(ii) speech therapy to develop or improve speech after surgery to correct a defect that both (a) existed at birth, or (b) impaired or would have impaired the ability to speak.

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

(j) Charges incurred for **elective sterilization** procedures and their reversal.

(k) Initial **contact lenses** or glasses required following cataract surgery.

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

(m) **Prescription Drugs** (as defined and approved by the Food and Drug Administration), prescribed by a Physician and dispensed by a licensed Pharmacist. A Standalone Prescription Drug Card Plan's copayment per prescription filled or refilled is eligible for reimbursement under this Plan.

(n) Scalp, **hair prostheses** prescribed or authorized by a Physician but only if they are furnished in connection with hair loss resulting from treatment of (i) disease by radiation or chemicals; (ii) alopecia universalis (totalis); or (iii) alopecia areata. The maximum amount that will be paid for any one (1) Covered Person during a twenty-four (24) month period is shown in the Schedule of Benefits.

(o) **Infertility treatment** for in vitro fertilization is covered for up to four (4) cycles, thereafter subject to medical review and Medical Necessity. Artificial insemination is covered for three (3) attempts per month up to six (6) cycles, thereafter subject to medical review and Medical Necessity.

(p) Charges incurred for elective **abortion**.

(q) The charges incurred for the **breast prosthesis** are covered when provided by and billed for by a Physician following recommended breast surgery.

(r) Charges for services rendered by a state **certified acupuncturist**, which are Medically Necessary.

(s) **Smoking cessation** programs when provided and prescribed by a Physician and Medically Necessary due to a severe lung Sickness, such as emphysema or asthma.

(t) Charges incurred for the **Pregnancy of a Dependent** daughter are covered the same as any other Sickness.

(u) **Cardiac** rehabilitation as deemed Medically Necessary provided services are rendered (i) under the supervision of a Physician; (ii) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (iii) initiated within twelve (12) weeks of the medical condition; and (iv) in Medical Care Facility as defined by this Plan.

(v) Charges incurred for the screening for **lead poisoning** and related follow-up treatment, including development assessment and all childhood immunizations which have been recommended by the U.S. Department of Public Health Services will be covered under this Plan, and the Plan deductible, if any, will be waived.

(w) Charges incurred for routine **pap smears** will be considered eligible under this Plan.

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

(y) Charges incurred for **spinal manipulation/chiropractic service**s by a licensed M.D., D.O. or D.C. will be considered eligible under this Plan as shown in the Schedule of Benefits when Medically Necessary and not considered maintenance.

(z) Charges for an **assistant surgeon**.

(aa) Charges incurred for a routine **mammography** will be covered as described in this Plan and shown in the Schedule of Benefits.

(bb) Charges incurred for a routine **prostate screening** and examination are covered as described in this Plan and shown in the Schedule of Benefits.

(cc) Charges incurred for **oral contraceptives** are eligible under this Plan, if not already covered and payable under a Prescription Drug Card Plan.

(dd) Charges for treatment due to an accidental Injury to natural teeth and **dental prosthesis** replacing accidentally injured teeth. (See Dental Care for additional information.)

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

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

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

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

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

(iii) coverage for prostheses and physician complication of all stages of a mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the Covered Person/patient.

INJURY TO OR CARE OF THE MOUTH, TEETH AND GUMS

Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under this Plan only if that care is for the following oral surgical procedures:

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

(2) Emergency repair due to accidental Injury to sound natural teeth and follow-up for dental prosthesis replacing accidentally injured teeth and any necessary follow-up care. This repair must be made within twelve (12) months from the date of an accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within twelve (12) months, this time may be extended.

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

(4) Excision of benign bony growths of the jaw and hard palate.

(5) External incision and drainage of cellulitis.

(6) Incision of sensory sinuses, salivary glands or ducts.

(7) Removal of impacted teeth.

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

THERAPY SERVICES

Charges for therapy services such as physical therapy, occupational therapy, speech therapy, chemotherapy, radiation therapy, inhalation therapy, infusion therapy and other therapy will be payable as shown in the Schedule of Benefits.

ASSOCIATED MEDICAL SERVICES

Charges for associated medical services will be payable as shown in the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT (DME) AND MEDICAL/SURGICAL SUPPLIES

Charges for durable medical equipment (DME) and medical/surgical supplies will be payable as shown in the Schedule of Benefits. Prior approval is required for durable medical equipment.

PROSTHETICS/ORTHOTICS

Charges for prosthetics/orthotics will be payable as shown in the Schedule of Benefits. This Plan provides benefits for the initial prosthetic/orthotic appliance or device when Medically Necessary. Additional provisions may be provided following a medical review of the diagnosis, medical condition and treatment plan to determine further Medical Necessity.

CARE AND TREATMENT OF JAW JOINT CONDITIONS INCLUDING TEMPOROMANDIBULAR JOINTS

Charges for the care and treatment of a jaw condition will be payable as shown in the Schedule of Benefits when Medically Necessary. The care and treatment may include diagnostic testing and evaluation, Physician office visits, physical therapy and a non-orthodontic removable appliance. A

complete treatment plan for such services requires prior evaluation and authorization. Services which are orthodontic or orthognathic in nature are not eligible.

TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE *(DRUG RELATED)*

Covered charges for care and treatment of Mental Disorders and Substance Abuse *(Drug Related)* will be limited as follows:

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

(2) Physician's visits are limited to one (1) treatment per day.

(3) Psychiatrists (M.D.), Psychologists (Ph.D.) or Counselors (Ph.D.) may bill this Plan directly. Other licensed mental health practitioners permitted by statute or regulation to bill directly may do so. All other mental health professionals must bill this Plan through these professionals.

(4) Partial Hospitalization *(Day Care)* visits by exchanging unused inpatient days for Partial Hospitalization visits on a two-for-one basis. Day Care is the care in an approved facility for less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period.

This Plan contains an unique automatic restoration provision which can restore benefits issued for Mental Disorders. This provision is applicable in the Calendar Year immediately following the initial Calendar Year in which benefits are paid for Mental Disorders. The patient must be a Covered Person at the beginning of the year the restoration begins. The maximum that may be restored in a Calendar Year is $2,000. The amount restored will be the lessor of $2,000 or the amount that will bring the total lifetime benefit to $20,000. A maximum restoration of $20,000 is available for the lifetime of the patient.

SHOCK THERAPY BENEFITS

Benefits are payable only under this Plan for charges for electroshock treatments, insular shock treatments and other similar treatments given for mental, psychoneurotic or personality disorder. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder. There is a limit of twelve (12) shock treatments in each Calendar Year, thereafter treatment is subject to a medical review and Medical Necessity.

ALCOHOLISM TREATMENT

If a Covered Person is admitted to a Detoxification Facility or a Residential Facility, this Plan will pay for the following services subject to each provision of this Plan and the provider rendering such services:

(1) room and board in a standard room;

(2) drugs and medicines approved by the Food and Drug Administration for use by the general public and used during the hospitalization;

(3) laboratory tests (no x-rays);

(4) individual and group therapy and individual counseling;

(5) psychological testing;

(6) counseling for the family of the person who is receiving covered inpatient services;

(7) occupational therapy (but not diversional or recreational therapy or activity).

This Plan will pay the cost of the following services when they are provided by a Residential Facility to a Covered Person who is being treated as an outpatient or when they are provided as aftercare by a Detoxification Facility:

(1) counseling for the family of the person who is receiving covered inpatient services;

(2) individual and group therapy.

ORGAN TRANSPLANT COVERAGE LIMITS

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational".

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

(1) The transplant must be performed to replace an organ or tissue of the Covered Person.

(2) The maximum benefit for all transplant procedures performed during a Covered Person's lifetime is shown in the Schedule of Benefits.

(3) Charges for obtaining donor organs are covered charges under this 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:

(a) evaluating the organ or tissue;

(b) removing the organ or tissue from the donor; and

(c) transportation and storage costs directly related to the donation of the organ or tissue and billed by the Hospital.

Benefit payments for donor charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits.

(4) If the organ donor is a Covered Person and the recipient is not, this Plan will not cover charges incurred for obtaining donor organ or tissue from the Covered Person.

DIALYSIS BENEFITS

This Plan will pay the cost of the dialysis as shown in the Schedule of Benefits when the services are provided and billed by a Hospital or by a Freestanding Dialysis Center. The facility must make arrangements for training, equipment, rental and supplies on behalf of the Covered Person/patient.

PREVENTIVE CARE

IMMUNIZATIONS & WELL CHILD CARE FOR CHILDREN

Charges for Well Child Care. Covered charges for routine well child care under this Plan are payable as shown in the Schedule of Benefits. Well child care includes routine pediatric care, a routine physical examination, related x-rays, laboratory tests and immunizations by a Physician that is not for Injury or Sickness.

Charges for Routine Well Adult Care. Covered charges for routine well adult care under this Plan are payable as shown in the Schedule of Benefits. Well adult care includes a routine physical examination, gynecological examination, related x-rays, laboratory tests, pap smear, mammography, prostate screening and tests, and immunizations by a Physician that is not for Injury or Sickness.

COVERAGE OF ROUTINE MAMMOGRAPHY

Charges incurred for a routine mammography are eligible as shown in the Schedule of Benefits for Covered Persons under this Plan and limited as follows: (a) ages thirty-five (35) through thirty-nine (39), one (1) Baseline mammography; (b) ages forty (40) through forty-nine (49), and (1) mammography every two (2) years; (c) age fifty (50) and over, one (1) annually.

COVERAGE OF ROUTINE PROSTATE SCREENING

Charges incurred for an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors are eligible under this Plan.

COVERAGE OF WELL NEWBORN NURSERY/PHYSICIAN CARE

Charges for Routine Nursery Care. Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under this Plan at the termination of the Pregnancy and the newborn child is an eligible Dependent. Care and treatment of a covered newborn child if (s)he is sick, injured, premature or born with a congenital birth defect are covered under this Plan.

The benefit is limited to the fee made by the Hospital for routine nursery care provided for the newborn child while Hospital confined as a result of the child's birth.

Charges for Routine Physician. The benefit is limited to the fee made by a Physician for the newborn child while Hospital confined is covered as a result of the child's birth.

Charges for covered routine Physician care such as examinations, tests and routine procedures such as circumcisions while Hospital confined are covered and will be applied toward the Plan of the newborn child.

COVERAGE FOR PREGNANCY

The fee for the care and treatment of Pregnancy is covered the same as any other Sickness.

The following limitations shall apply:

(1) Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider, after consultation of the mother, discharges the mother or newborn earlier,

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Plan Administrator.

(2) If this Plan offers coverage for post-delivery care to a mother and her newborn child in the home, the providers of coverage are not required to provide inpatient care unless it is determined to be Medically Necessary by the attending Physician or is requested by the mother.

Note: This Plan's benefit apply to both obstetrical care for the mother and the newborn child's initial stay in the Hospital. After the child's birth, the covered Employee has sixty (60) days to enroll the child under this Plan. If the child is enrolled within sixty (60) days, bills related to medical care for the child will continue to be paid through this Plan. If the child is not enrolled within sixty (60) days, coverage for the child under this Plan will terminate when the child leaves the Hospital after birth.

In some instances, this Plan will also provide payment for bills related to the birth of a newborn grandchild. In order for benefits to be available, the newborn's mother must be enrolled as a covered Dependent (1) wholly dependent on the covered Employee for support and maintenance; (2) be living with the covered Employee; (3) be under the limiting age for Medical Coverage; and (4) be unmarried. Coverage for the newborn grandchild ends when the covered Dependent (the newborn's mother) is discharged from the Hospital. The grandparent(s) may apply for coverage of the newborn grandchild under this Plan if (s)he obtains legal custody of the newborn grandchild.

MEDICAL NECESSITY

This Plan provides payment for benefits under this Plan only when:

(1) Services are performed or prescribed by a Physician; and

(2) Services are provided at the proper level of care (inpatient, outpatient or out of the Hospital); and

(3) Services or supplies are Medically Necessary for the treatment of diagnosis of a Sickness or Injury.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in itself, make it Medically Necessary for the treatment or diagnosis of an Injury or Sickness.

If this Plan determines that a service eligible under this Plan can be provided in a setting which is medically acceptable, a cost-effective alternative method of care, this Plan reserves the right to provide benefits for such services when performed in the alternative setting.

IMPORTANT: Maintenance treatments are considered to be not Medically Necessary and are, therefore, not eligible for coverage under this Plan. Frequently, treatment for a chronic condition, such as a bad back, reaches a plateau. That is, treatment brings a Covered Person to a point where further treatment cannot be reasonably expected to improve a Covered Person's condition. Instead, it maintains a Covered Person's current condition. This often happens in conditions treated by chiropractic manipulation or physical therapy. When such a point is reached further treatment is deemed to be maintenance and is no longer eligible for coverage under this Plan.

IMPORTANT: Modifications to and equipment for an automobile to make it accessible and drivable by an individual with a disability are considered not Medically Necessary. Modification to a residence to make it accessible are also deemed to be not Medically Necessary.

COST MANAGEMENT BENEFITS

The Utilization Management Service

Refer to the Medical identification card for the telephone number of the current Utilization Management Service.

This Plan has implemented a ***Utilization Management Service*** to bring participants actively into the role of selecting the appropriate level of delivery for the Covered Person's health care needs. Utilization Management is a review process utilizing established criteria and standards that address the planned services or treatment before they are rendered, as well as monitoring continued treatment.

Utilization Management consists of the following:

* Certification of the Medical Necessity for all non-emergency Hospital or inpatient admissions before medical services are provided;

* Retrospective review of the Medical Necessity for all emergency Hospital admissions;

* Concurrent review, based on the admitting diagnosis, of the number of days of Hospital confinement requested by the attending Physician; and

* Certification of the length of confinement and discharge planning.

The goal of the Utilization Management is to help assure that all Covered Persons receive necessary and appropriate health care, while avoiding unnecessary expenses to both the Covered Person and this Plan.

In order to be effective and maximize this Plan's reimbursement, please read the following provisions carefully. Failure to comply with the outlined procedures may result in a reduction of benefits.

INPATIENT PRE-ADMISSION CERTIFICATION REQUIREMENTS

A Covered Person, Physician or relative should certify:

* A non-emergency Hospital or inpatient admission at least five (5) business days in advance of a scheduled inpatient admission.

* An emergency admission (those admissions which cannot be scheduled in advance) within forty-eight (48) hours or by the next business day following the admission.

* For maternity admissions during the first trimester and within one (1) day following hospitalization.

To certify or report an admission, a Covered Person, Physician or relative should call the ***Utilization Management Service*** with the following information:

* Name of patient, and relationship to the Covered Person, if a dependent
* Name, Social Security number and address of the Covered Person
* Name of the Group
* Name and telephone number of the attending Physician
* Name of the Hospital and proposed date of admission
* Diagnosis and/or type of surgery
* Proposed length of stay

It is the responsibility of the Covered Person and/or Covered Dependent to inform the Physician and/or Hospital that this Plan has a Pre-Admission Certification Program. Inpatient admissions not certified or authorized by the Utilization Management Service will be subject to a reduction of benefits.

Inpatient admissions not certified or authorized by the Utilization Management Service will be subject to a reduction of benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000, out-of-pocket cost per Covered Person per Calendar Year, not including this Plan's deductible and coinsurance.

Should it be impossible for a Hospital or inpatient admission to be certified (for example, because the Covered Person/patient is unconscious, a relative is unaware of the requirements or, if due to a clerical error) a person may appeal the reduction of benefits. Please refer to the "Claims Appeal Procedures" as outlined in the benefit booklet for this process.

CONCURRENT STAY REVIEW/DISCHARGE PLANNING

As part of the Utilization Management process, the ***Utilization Management Service*** will monitor the Covered Person's Hospital stay and coordinate with the attending Physician, Hospital and Covered Person/patient either the scheduled release from the Hospital or an extension of the Hospital admission.

If the attending Physician feels that it is Medically Necessary for a Covered Person/patient to remain hospitalized for a length of time greater than has been certified, the Physician must notify the Utilization Management Service of the need for additional days.

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

EMERGENCY SERVICES

In case of medical emergency, one should go to the nearest emergency facility. When receiving emergency care, one must contact the ***Utilization Management Service*** within forty-eight (48) hours of the emergency treatment in order to be eligible to receive maximum benefits. The applicable copayment is waived if admitted.

OUT OF THE AREA EMERGENCY CARE SERVICES

In cases of medical emergency, one should go to the nearest emergency facility. When receiving emergency care, one must contact the ***Utilization Management Service*** within forty-eight (48) hours of the emergency treatment in order to be eligible to receive maximum benefits or continue In-network benefits.

SURGICAL PROCEDURES & SECOND OPINIONS

Certain surgical procedures may be performed either inappropriately or unnecessarily. In some cases, surgery is only one (1) of the several treatment options. As patterns of medical practices change, the specific procedures which may require a Second Opinion may also change.

A Covered Person, Physician or relative should certify non-emergency surgical procedures by calling the ***Utilization Management Service*** in advance of the scheduled procedure. The ***Utilization Management Service*** will review all information and determine whether or not a Second Surgical Opinion consultation is required.

These additional consultations must be performed by Physicians who are not financially associated with either of the surgeon originally recommending surgery or professionally in practice with each other.

If the second opinion does not confirm the need for surgery, a third opinion may be obtained for the recommended surgery. 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. All such consultations will be paid at the rate of 100% for Network Providers. When such consultations are provided by Non-Network Providers, they will be paid at a rate of 80% subject to the deductible.

Surgical procedures not certified or authorized by the Utilization Management Service will result in a reduction of or in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including this Plan's deductible and coinsurance.

SECOND SURGICAL REVIEW LIST

Contact the ***Utilization Management Service*** when a surgical procedure has been recommended. Non-emergency surgical procedures which may require a Second Surgical Opinion are listed as follows:

Arthroscopy with Meniscectomy (see Meniscectomy)
Bunionectomy (removal of bunions)
Bowel Resection (Removal of portion of bowel)
Bypass Surgery (Coronary, Gastric, Intestinal)
Cataract Extractions
Cholecystectomy (Excision of Gallbladder)
Coronary Artery Bypass (Heart Bypass)
Dilation & Curettage (Expansion & Scraping)
Discectomy (Removal of disc)
Herniorrhaphy (Hernia Procedure)
Hemorrhoidectomy (Removal of Hemorrhoids)
Hysterectomy (Removal of Uterus)
Laminectomy (Spinal Surgery)
Laparotomy (Incision of Abdomen)
Mastectomy (Breast Surgery)
Meniscectomy (Knee Surgery)
Myringotomy (Tube Insertion)
Oophorectomy (Incision of Ovary)
Prostatectomy (Removal or Resection of the Prostate)
Replacement (Total Joint)
Salpingectomy (Removal of Fallopian Tubes)
Salpingo-Oophorectomy (Excision Ovary/Removal of Fallopian Tubes)
Tonsillectomy and/or Adenoidectomy
Chemonucleolysis (Nerve Cell Inflammation)
Valve Replacement
Varicose Vein (Stripping & Ligation)
Nasal Surgery

Any procedure which could be considered cosmetic in nature:

* Abdominal lipectomy (Excision of fatty tissue)
* Eyelid surgery
* Breast reduction or augmentation
* Mastectomy for gynecomastia (Excision of male mammary glands)
* Dermabrasion (Skin Abrasions)
* Otoplasty (Ear plastic surgery)
* Rhinoplasty (Nose plastic surgery)
* Rhytidectomy (Wrinkle Removal)
* Scar revisions

PRECERTIFICATION REQUIRED FOR OTHER MEDICAL SERVICES

Certain other medical services and/or supplies, as shown in the Schedule of Benefits and the Benefit Summary are required to be precertified or authorized. Any such services and/or supplies which are not precertified or authorized will be subject to the non-compliance penalty assessed by this Plan.

HIGH RISK MATERNITY REVIEW PROGRAM

The High Risk Maternity Review Program focuses on an early identification and intervention of potential high risk pregnancies and the subsequent case management of appropriate and approved medical services needed to protect the health of both the mother and child.

During the first trimester, High Risk Maternity Review begins with a call from the Covered Person/patient or attending Physician to the ***Utilization Management Service*** for an initial screening. A risk assessment is taken and the treatment plan is reviewed. If a high risk situation is identified the case management process is initiated.

The ***Utilization Management Service*** will initiate a second screening during the 24^{th} – 26^{th} week of gestation. If a risk is identified during this screening the Covered Person/patient's Physician is contacted regarding the appropriate treatment planning.

A Final Screening will be conducted after the birth of the child to address any questions the Covered Person/patient may have and determine if any further treatment is necessary.

LARGE CASE MANAGEMENT

Often it is most efficient and more convenient for both this Plan and the family of the Covered Person to have this Plan provide active management of care and its delivery.

When a Covered Person has been identified with a medical condition or catastrophic Illness (such as a spinal cord Injury, a degenerative Illness or a neurological paralytic disease, multiple birth defect, stroke, terminal or chronic Illness, etc.), that Covered Person may require long term or lifetime care, or complicated patterns of care. In addition, when medical care costs for a particular condition are expected to exceed a certain dollar amount, and there is a potential for alternative treatment or an alternate setting, then the case may be referred for Large Case Management (LCM).

LCM is a program which provides an individual case analysis and medical treatment plan recommendations to address the needs of the catastrophically ill or injured individual. The decision to implement **LCM** will be determined by the stated criteria set forth by this Plan.

A case manager will contact the Covered Person and/or family to explain about case management. The case manager, team of Physicians and rehabilitation nurses work with the attending Physician and the Covered Person to develop a cost effective, long term plan of care that maximizes Plan resources, eliminates excess services and meets the individual Covered Person's needs.

In certain circumstances a recommendation to use alternative treatment, not normally covered by this Plan, may be suggested when such treatment endorses quality care, Medical Necessity and cost effectiveness. Under these circumstances any such suggested alternative treatment will be covered by this Plan.

Note: This is a voluntary service. The Covered Person/patient and family are requested to review the recommended alternative treatment plan. The final determination regarding the services to be rendered is the decision of the Covered Person/patient and/or family and the attending Physician. There is no reduction of benefits or penalties imposed if the Covered Person/patient and family choose not to participate.

PLAN EXCLUSIONS

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

(1) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under this Plan.

(2) **Cosmetic services.** Care and treatment, and any related services or supplies provided for cosmetic reasons which are performed primarily to alter or improve any portion of the body. This exclusion will not apply if the care and treatment, services or supplies are provided for or performed for the:

(a) Repair of any deformities or defects of a bodily part resulting from an accidental Injury;

(b) Replacement of diseased tissue as a result of a Sickness and/or which has been surgically removed; or

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

(d) Reconstructive mammoplasty following Medically Necessary surgery;

This exclusion does not apply to reconstructive surgery specifically named in this Plan.

(3) **Custodial Care.** Services or supplies provided mainly as a rest cure, or services rendered such as in rest homes, old age homes or services or supplies provided as maintenance or Custodial Care.

(4) **Dental Work.** Charges for Physician services or x-ray examinations for a mouth condition. "Mouth condition" means only a condition involving one (1) or more teeth, the tissue or structure around them or the alveolar process of the gums. This exclusion applies even if a condition requiring any of these services involve a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorder (TMJ), unless pre-approved or malocclusion, involving joints or muscles by the methods including, but not limited to,

crowning, wiring, or repositioning teeth. However, benefits may be provided under the criteria set forth under covered services when Medically Necessary.

(5) **Educational and vocational training.** Services for educational, developmental or vocational counseling, testing or training.

(6) **Equipment.** Charges for services involving equipment or facilities used when the purchase, rental or construction of them has not been approved in compliance with applicable state laws and regulations.

(7) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge or pre-negotiated contracted rate, whichever applies. A Usual and Reasonable Charge is the usual charge by a Physician or facility in the area for like services and supplies. The pre-negotiated contracted rate is the fee Network Providers agreed to accept for services rendered. If a charge for any service or supply is higher than the usual charge, a Plan Participant is responsible for the difference between the usual and the actual charge. If a charge for any service or supply is higher than the pre-negotiated contracted charge, a Plan Participant is not responsible for an amount over the pre-negotiated contracted rate.

(8) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised occupational or physical therapy covered by this Plan.

(9) **Experimental/Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(10) **Eye Care.** Charges for (a) eye surgery such as radial keratotomy, to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring) whether performed for cosmetic or work related purposes; (b) routine eye examinations, including refractions, eyeglasses, contact lenses, or any type of external appliances used to improve the visual acuity and their fittings, unless as specifically stated as covered under this Plan.

This Plan will cover the (a) first pair of eyeglasses which a Physician prescribes after cataract surgery; (b) initial replacement lenses for loss of natural lens; (c) services for aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(11) **Foot Care.** Physician charges for:

(a) a weak, strained, flat, unstable or imbalanced foot or a metatarsalgia or a bunion. However, this does not apply to charges for an open cutting operation; and

(b) one (1) or more corns, calluses or toenails. This does not apply to a charge for the removal of part of all of a nail root and services connected with treating metabolic or peripheral vascular disease.

(12) **Governmental Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(13) **Hair Loss.** Care and treatment for hair loss including hair transplants, hair weaving, hair implants, wigs, toupees or any other drug that promise hair growth whether or not prescribed by a Physician, except for a wig prescribed following chemotherapy which is covered up to the limit as shown in the Schedule of Benefits.

(14) **Hearing aid and exams.** Hearing aids and hearing examinations to determine the need for hearing aids unless such care is specifically covered in the Schedule of Benefits; fitting and adjustments of hearing aids will not be covered no matter what the cause of the hearing loss.

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

(16) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior.

(17) **Medicare.** Charges that should have been paid by Medicare if Medicare coverage had been in effect.

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

(19) **No obligation to pay.** Charges incurred for which this Plan has no legal obligation to pay.

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

(21) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.

(22) **Occupational.** Care and treatment of an Injury, Sickness or disease that is occupational – that is, arises from work for wage or profit including self-employment, that is covered by reason of its relation to work by any workers' compensation law, occupational disease laws or similar laws. **If a Covered Person collects benefits for the same Injury or Sickness from both Workers' Compensation and this Plan, the Covered Person may be subject to prosecution for fraud.**

(23) **Personal comfort and other medical supplies.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

(24) **Plan design exclusion.** Charges excluded by this Plan design as mentioned in this document.

(25) **Private duty nursing.** Charges for private duty nursing which is determined not to be Medically Necessary. Private duty nursing will not be covered if the care is:

(a) rendered by or could be provided by home health aides or any nurses' aides;

(b) custodial care or assistance in the activities of daily living in a home, Hospital or facility of any kind; or

(c) the type of care normally provided by or that should be provided by a Hospital nursing staff.

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

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

(28) **Routine care.** Charges for routine or periodic physical examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

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

(30) **Sex changes.** Care, services or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(31) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(32) **Smoking cessations.** Care and treatment for smoking cessation programs unless Medically Necessary due to a severe active lung Sickness such as emphysema or asthma. Smoking deterrent patches and nicotine gum are not covered.

(33) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(34) **War.** Any loss that is due to a declared or undeclared act of war.

(35) **Weight Loss.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

SECTION V

DEFINED TERMS

The following terms and phrases shall have the following meanings, unless a different meaning is plainly required by the context. These are general definitions and the presences of any definition in this section is not, in and of itself, the indication of the existence of a benefit.

Active Employee is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the covered Employer at least twenty (20) hours per week.

Active Employee Requirement is the requirement of this Plan relating to the status of "Active Employee" discussed in the "Eligibility" portion of Section II.

Activities of Daily Living are the day-to-day activities, such as continence, dressing, feeding, toileting and transferring.

Alcoholism is the condition caused by regular excessive compulsive drinking of alcohol that results in a chronic disorder affecting physical health and/or personal or social functioning.

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

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

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

Allowable Charges/Expenses is any Usual and Customary Charge(s) incurred:

(1) for a Medically Necessary service or supply; when

(2) the charge, service or supply is covered at least in part by one (1) or more plans of the same type (dental or medical) covering the person making the claim.

(3) In the event that payments have been made by this Plan in amounts in excess of those necessary to satisfy the intent of this Plan, the Plan Administrator reserves the right to recover such excess payments from the individual and/or entity to which the payments were made.

Ambulance is a specially designed vehicle transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment and other life saving equipment required by the state and local law and that is staffed by personnel trained to provide first aid treatment.

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.

Amendment is the formal process and resulting document that changes the provisions of this Plan Document, duly signed by the authorized person(s) as designated by the Plan Administrator.

Area means a county or larger geographic area, if a larger area is required, needed to obtain a representative level of Usual and Reasonable Charges.

Baseline shall mean the initial Test Results to which the results in the future years will be compared in order to detect abnormalities.

Basic Benefit means that portion of this Plan that provides coverage for eligible charges paid according to a "first-dollar" basis either in full or at a specific fee schedule.

Benefit Percentage/Coinsurance means that a portion of eligible expenses to be paid by this Plan in accordance with the coverage provisions as stated in this Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual deductible which are to be paid by the Plan Participant, if any.

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 (no more than 24 hours); provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

Certified Registered Nurse Anesthetist (CRNA) is a Registered Nurse certified to administer anesthesia, who is employed by and under the personal supervision of a Physician Anesthesiologist.

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

Coinsurance means the percentage of charges that a Covered Person is required to pay for eligible charges/expenses under this Plan.

Complications of Pregnancy are determined as follows:

(1) These conditions are included before the Pregnancy ends; acute nephritis; nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

(2) Complications will also include: ectopic Pregnancy; cesarian section; and miscarriage or abortion where a live birth is not possible.

(3) Conditions that are not medically termed as Complications of Pregnancy.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Coverage is the plan design of payment for medical expenses under this Plan.

Covered Person means the Plan Participant and any/all covered Dependents.

Creditable Coverage is prior coverage of an eligible person which counts toward reducing or eliminating a Pre-Existing Conditions Limitation if any applies to this Plan. "Creditable Coverage" includes most health coverage, such as, coverage under a group health plan (including COBRA continuation coverage, HMO membership, and individual health insurance policy, Medicaid or Medicare).

Creditable coverage does not include coverage consisting solely of "expected benefits", such as coverage solely for dental or vision benefits.

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

Day and Night Psychiatric Facility is a facility which is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Disorders/Substance Abuse (*Drug Related)* only during the day or during the night.

Day Care refers to services, supplies and treatment in an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period.

Deductible(s) (as may be applicable to this specific Health Care Choice Plan), is the amount of eligible covered charges for which no benefit will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible (the dollar amount indicated) shown in this Plan's Schedule of Benefits.

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

Diagnostic Services are procedures ordered by a Physician or professional because of a specific symptom to determine a definite condition or disease.

Drug Abuse is a physical, habitual dependence on drugs. This includes (but is not limited to) dependence on drugs that are medically prescribed. This does not include dependence on alcohol, tobacco and ordinary caffeine-containing drinks.

Durable Medical/Surgical Equipment and Supplies are (1) primarily and customarily used for medical purposes and are not generally useful in the absence of a Sickness or Injury; (2) can effectively be used in a non-medical facility (home); (3) are expected to make a significant contribution to the treatment of a Sickness or Injury; (4) are used solely for the care and treatment of the patient; and (5) are priced so that the cost of the equipment/supplies is proportionate to the therapeutic benefits which can be derived from the use of the equipment/supplies.

Elective Surgical Procedure or Surgery is a non-emergency surgical procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Eligible Charges are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined in this Plan.

Eligibility Requirements are the eligibility requirements of this Plan discussed in the "Eligibility" portion of Section II.

Employee means any Employee of the Employer who meets the eligibility criteria as set forth in the Eligibility section of this Plan. For the purposes of this Plan, former Employees, Retirees and Elected and/or Appointed Officials (as applicable) of the Employer may be eligible for coverage, if so designated by the Employer as set forth in the Eligibility section of this Plan.

Employer/County Agency/Local Unit of Government/Municipality/Plan Sponsor as applicable is: Middlesex County.

Enrollment Date is the first day of coverage. If there is a Waiting Period, the first day after completion of the Waiting Period.

Enrollment Requirements are the enrollment requirements of this Plan discussed in the "Enrollment" portion of Section II.

Executive Committee (as applicable) means the Committee established pursuant to the bylaws of the joint health insurance fund to govern or manage the risk management programs, joint self-insurance fund or funds and related services of the group.

Experimental and/or Investigational means services, supplies, care and treatment which do 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.

In determining coverage under this Plan, the Plan Administrator shall make an independent evaluation of the experimental status of specific technologies and shall be guided by a reasonable interpretation of the Plan provisions. The decision(s) shall be made in good faith and will be rendered following a detailed factual background investigation of the claim and the proposed treatment. In making such a determination, 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, device, 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.

The decisions of the Plan Administrator will be final and binding on this Plan.

Explanation of Benefits (EOB) is a document that accompanies a claims check and summarizes how reimbursement was determined.

Facility Charges are charges from an approved medical institution such as a Hospital, Residential Facility, Detoxification Facility, Ambulatory or Freestanding Surgical Center.

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

First-Dollar Basis (as may be applicable to this Plan), is a provision of a benefit plan that provides reimbursement for incurred health care costs "from the first dollar" with no deductible.

Foster Child means an unmarried child under the age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation, and who meets all of the following criteria: (1) the child is being raised as the covered Employee's; and (2) the child depends on the covered Employee for primary support; and (3) the child lives in the home of the Covered Employee; and (4) the covered Employee may legally claim the child as a federal income tax deduction.

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

Freestanding Dialysis Facility is a facility which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.

Fund or **Joint Insurance Fund** (as applicable) means:

(1) a group established by two or more Local Units of Government to create an insurance fund for the purpose(s) of providing contributory or non-contributory group health insurance or group term life insurance to their Employees or Dependents and to any other person eligible for coverage by a member Local Unit pursuant to law, approved by the Department of Insurance pursuant to N.J.S.A. §40A:10-36, *et. seq.* and N.J.A.C. §11:15-3.1, *et. seq.*

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 genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Maintenance Organization (HMO) is a prepaid medical group practice plan that provides a comprehensive predetermined medical care benefit package to enrolled groups at a predetermined price. The HMO can be sponsored by the government, medical schools, Hospitals, employers, labor unions, consumer groups, insurance companies, and Hospital-Medical plans. HMOs are both insurers and providers of health care. HMOs provide well-care and preventive medicine, and the enrolled participants' health care is managed by Primary Care Physicians.

Home Health Care Agency is an agency that meets all of the following tests: (1) its main function is to provide Home Health Care Services and Supplies; and (2) it is federally certified as a Home Health Care Agency; and (3) it is licensed by the state in which it is located, if licensing is required.

Home Health Care Aide means a person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Plan must meet the following tests: (1) it must be a formal written plan made by the patient's attending Physician; (2) it must be reviewed at least every thirty (30) days; (3) it must state the diagnosis; (4) it must certify that the home health care is in place of Hospital confinement; and (5) it must specify the type and extent of home health care required for the treatment of the Covered Person/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 agency that provides Hospice Care Services and Supplies and is appropriately credentialed and licensed by the state(s) in which it is located and operates to provide such services.

Hospice Care Plan is a plan of terminal Covered Person/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 includes: 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 (2) unrelated persons who are expected to die within six (6) 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 Covered Person/patient's expense and which fully meets these tests: (1) it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; (2) it is approved by Medicare as a Hospital; (3) 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; (4) it continuously provides on the premises twenty-four (24) hour-a-day nursing services by or under the supervision of Registered Nurses (R.N.s); and (5) it is operated continuously with organized facilities for operative surgery on the premises.

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

(1) A facility operating legally as a psychiatric Hospital and licensed as such by the state in which the facility operates.

(2) 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 fifteen (15) resident patients; has a Physician in regular attendance; continuously provides twenty-four (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.

(3) It is licensed as an Ambulatory or Freestanding Surgical Center. The center must mainly provide outpatient surgical care and treatment.

(4) It is an institution for the treatment of Alcoholism which is:

  (a) a licensed Hospital; or

  (b) a licensed Detoxification Facility; or

(c) a Residential Facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.

(5) It is a Birthing Center that is licensed, certified or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:

(a) it is equipped and operated mainly to provide an alternative method of childbirth;

(b) it is under the direction of a Physician;

(c) it allows only Physicians to perform surgery;

(d) it requires an exam by an Obstetrician at least once before delivery;

(e) it offers prenatal and postpartum care;

(f) it has at least two (2) birthing rooms;

(g) it has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator;

(h) it has the services of registered graduate nurses;

(i) it has written agreements with one (1) or more Hospitals in the area and will immediately accept patients who develop complications or require post-delivery confinements;

(j) it provides for periodic review by an outside agency;

(k) it maintains proper medical records for each patient.

The definition of a "Hospital" shall not include a nursing home. Neither does it include an institution, nor part of one, that:

(a) is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts;

(b) is used mainly as a center for the treatment and education of children with Mental Disorders; or

(c) provides homelike or custodial care.

Hospitalization Benefits are benefits provided under this Plan for Hospital charges incurred by a Covered Person because of a Sickness or Injury.

Hospital Confinement or **Confined in a Hospital** means a Covered Person is:

(1) a registered bed patient in a Hospital upon recommendation of a Physician;

(2) an outpatient in a Hospital because of (a) chemotherapy treatment; (b) surgery; (c) planned tests ordered by a Physician before inpatient admission to the same Hospital; or (d) treatment of Alcoholism;

(3) receiving emergency care in a Hospital for an Injury on his/her first visit as an outpatient within forty-eight (48) hours after the Injury is received;

(4) partially confined for treatment of Mental Disorders, Substance Abuse (Drug Related) or other related Sickness. Two (2) days of being partially confined will be equal to one (1) day of being confined in a Hospital.

Illness is any disorder of the body or mind of a Covered Person, but not an Injury; pregnancy of a Covered Person, including abortion miscarriage or childbirth.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry, defined further as the disease of phenylketonuria (PKU), the body's failure to oxidize an amino acid; galactosemia, the inability to convert glucose; and hypothyroidism, a deficiency of thyroid secretion resulting in lowered basal metabolism defined as an amount of energy needed for maintenance of life.

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 definition includes what is referred to as a "coronary care unit" or acute care unit" or "neonatal care unit" or "burn unit." In any event, all Intensive Care Units shall have: 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 (2) beds for the accommodation of the critically ill; and at least one (1) Registered Nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee means a Plan Participant who enrolls under this Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under this 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 of and managing the property and rights of a minor child.
Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under the Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Local Unit of Government, Local Unit or County Agency or **Public Entity** means a county, municipality, county Hospital, county vocational school (pursuant to N.J.S.A. §18A:18B-8 and

§40A:10-50), county college (pursuant to N.J.S.A. §18A:64A-25.40 and §40A:10-51 (or any contracting unit as defined in N.J.S.A. §40A:11-2.

Low Protein Modified Food Product means a food product that is specially formulated to have less than one (1) gram of protein per serving and is intended to be used under the direction of a Physician for dietary treatment of an Inherited Metabolic Disease, but does not include a natural food that is naturally low in protein, and "medical food" means a food that is intended for dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

Medicaid is Title XIX (grants to states for medical assistance programs) of the United States Social Security Act, as amended.

Medical Care is the professional services rendered by a Physician or professional provider for the treatment of a Sickness or Injury.

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 the sudden and unexpected onset of a condition with acute symptoms requiring immediate medical care. Medical Emergencies shall include conditions as found in heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, poisonings, acute abdominal pain, or other such medical conditions.

In addition, Medical Emergency includes a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the Covered Person harming himself and/or other persons.

Medically Necessary means services or supplies furnished by a provider not excluded under this Plan, to treat or diagnose a Sickness or Injury, and which as determined by the Plan Administrator, are:

(1) consistent with the symptoms or diagnosis; and

(2) not primarily for the convenience of the Covered Person or provider; and

(3) is the most appropriate level of services which can be safely provided to the Covered Person; and

(4) is not conducted for experimental, educational or research purposes; and

(5) is medically proven to be effective treatment of the condition; and

(6) commonly and customarily recognized by the medical profession as appropriate in the diagnosis and treatment of the Sickness or Injury.

Note: The fact that a provider may prescribe, recommend, order or approve a service or supply does not, of itself, determine it to be 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 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 one hundred (100) pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the Covered Person.

Municipality means a Local Unit of Government or any contracting unit as defined in N.J.S.A. §40A:11-2.

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

Non-Occupational Disease or Injury means a Sickness or Injury which does not arise out of, and which is not caused or contributed to by, nor is a consequence of, or in the course of, any employment or occupation for compensation or profit.

Non-Participating Provider or Non-Network Provider is a provider, such as a Physician, Hospital or other health facility or provider who is not under a contractual agreement with this Plan to provide care or services to Covered Persons.

Outpatient Care is treatment including services, supplies and medicines provided and used in the following circumstances: (1) at a Hospital under the direction of a Physician to a Covered Person not admitted as a registered bed patient; (2) services rendered in a Physician's office, laboratory, x-ray facility, or at an Ambulatory Surgical Center, or (3) at the Covered Person/patient's home.

Partial Hospitalization (Day Care) is the process of unused inpatient days being exchanged for Partial Hospitalization visits on a two for one basis. (One (1) inpatient day equals two (2) Partial Hospitalization visits).

Participating Provider or Network Provider is a provider, such as a Physician, Hospital or other health facility or provider who is under a contractual agreement with this Plan to provide care or services to Covered Persons.

Peer Review is the process whereby a provider's suggested or already rendered services to a patient are reviewed by a provider of similar profession and licensing. The review seeks: (1) to gauge the treatment against accepted practice guidelines of the applicable profession; (2) to determine the necessity/appropriateness of the indicated procedure and modality (considering alternative intervention); and (3) to assess the reimbursement of the procedure according to the terms of the applicable Plan Document.

Period of Hospital Confinement is the period a Covered Person is confined as a bed patient in a Hospital. Hospital confinements due to the same or related causes will be considered the same Hospital confinement unless separated by at least ninety (90) full days.

Pharmacy means a facility where covered Prescription Drugs are filled and dispensed by a Pharmacist(s) licensed under the laws of the state in which the facility operates. As applicable, the facility itself is to comply with all federal and/or state credentialing and licensing requirements.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Licensed Professional Physical Therapist, Physiotherapist, Occupational Therapist, Optometrist (O.D.), Certified Nurse Anesthetist, Midwife, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist and any other practitioner of the healing arts that is licensed and/or regulated by a state or federal agency and is acting within the scope of their license (as applicable).

Plan Participant(s) are, for purposes of this Plan, Active Employees, Retirees, Elected and/or Appointed Officials (as applicable) of the Employer, and Dependents, and former Employees and Dependents (COBRA participants), who may be eligible for coverage, if so designated by the Employer as set forth in the Eligibility section of this Plan, and have elected to be covered under this Plan.

Plan Year is the twelve (12) month period beginning on either the Effective date of this Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Preferred Provider as may be applicable to this Plan, means a Physician, group of Physicians, Hospital, or other healthcare provider (including a Pharmacy, if any) which participates in a Network, PPO or HMO that offers services to Covered Persons under this Plan.

Preferred Provider Organization (PPO) is a provider arrangement between this Plan and certain Hospitals, Physicians and other health care providers (who are called Network Providers or Preferred Providers), to offer services to this Plan and its Covered Persons at pre-negotiated rates. Through this arrangement, fees charged by Preferred Providers are generally lower than charges made by Non-Participating Providers.

Pregnancy is childbirth and conditions associated with Pregnancy, including Complication of Pregnancy.

Prescription Drug shall mean: (1) any drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; and (2) is approved for sale and use in the United States at the dosage and indications approved by the Food and Drug Administration; and (3) is Medically Necessary in the treatment of a Covered Person's Sickness or Injury; and (4) shall also include injectable insulin and hypodermic needles/syringes, but only when dispensed upon a written prescription.

Primary Care Physician as may be applicable to this Plan, each Covered Person may select his or her own Primary Care Physician (PCP) from the provided Network Directory of the contracted Network. PCPs are Family Physicians, General Practitioners, Internists and Pediatricians. Services beyond the expertise of the PCP shall require a referral for specialist medical care (as applicable).

Psychologist means a person who is licensed or certified as a Clinical Psychologist, or a person without a license who is qualified as a Clinical Psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if they are operating within the scope of their license.

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

Residential/Detoxification Facility means an institution which is licensed, certified or approved pursuant to state and local laws as a facility for the treatment of Alcoholism.

Retired Employee/Retiree as may be applicable to this Plan, this term refers to a former Active Employee of the Employer who retired while employed by the Employer under the formal written plan of the Employer and meets the eligibility requirements of the Employer for continuation of coverage under this Plan.

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

Schedule of Benefits refers to the outline of Covered Benefits as shown in this Medical Benefits Plan.

Semi-Private means "semi-private" room accommodations of at least two (2) beds.

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

Skilled Nursing Facility/Extended Care Facility is a facility that meets all of the following tests:

(1) It is licensed to provide professional nursing services on an inpatient basis for persons convalescing from Injury or Sickness.

(2) Its services are provided for compensation from its patients and under the full time supervision of a Physician or a Registered Nurse.

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

(4) It provides services to assist patients in attaining a higher degree of body functioning, and provides services to help restore patients' self care skills in essential daily living activities.

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

(6) It has an effective utilization review plan.

(7) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of Mental Disorders.

(8) It is approved and licensed by Medicare.

(9) "Hospital" shall be interpreted to include an Extended Care Facility.

Special Care Facility means a facility other than as a Skilled Nursing Home or Hospital as defined under this Plan, which:

(1) Specializes either in physical rehabilitation or in the diagnosis and treatment of Mental Disorders; or

(2) Qualifies as a Skilled Nursing Facility or provider of services under Medicare; but only if that institution:

(a) maintains on the premises facilities necessary for medical treatment;

(b) provides such treatment for compensation, under the supervision of Physicians; and

(c) provides nurses' services

All such facilities must be credentialed and/or licensed by federal and/or state authorities to provide the services to which the incurred charges relate.

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.

Spouse means the legally recognized marital partner of an Employee.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing drinks.

Surgical Center is an Ambulatory Care Facility licensed by a state to provide same day surgical services.

Surgical Expense Benefit means the payment(s) this Plan will make for surgical procedures, upon the proof (satisfactory to the Plan Administrator) that the services were Medically Necessary recommended and approved by a Physician. On such terms, this Plan will pay allowances for the

procedure(s) according to the Usual and Reasonable Charges, or according to a fee schedule (as applicable).

Surgical Procedure refers to medical procedures which involve: incising, excising, suturing, electrocauterization, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, tapping, aspiration, administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Temporomandibular Joint Syndrome (TMJ) is the treatment of jaw/joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Coverage under this Plan requires a complete treatment plan be forwarded to the Plan Administrator.

(1) Care and treatment includes, but is not limited to, diagnostic testing and evaluation, Physician office visits, physical therapy, and any non-orthodontic removable appliance that is attached to or rests on the teeth.

(2) Services which are orthodontic or orthognathic in nature are not covered.

Therapy Services are services supplied by a licensed Physician or professional provider acting within the scope of their license(s) and certification(s) (as applicable) and used for the treatment of a Sickness or Injury to promote the recovery of a Covered Person.

(1) Chemotherapy is the treatment of malignant diseases by chemical or biological antineoplastic agents.

(2) Dialysis Treatment is the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis and peritoneal dialysis.

(3) Physical Therapy is the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following Sickness, Injury or loss of body part.

(4) Occupational Therapy is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the Covered Person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the Covered Person’s particular occupational role.

(5) Radiation Therapy is the treatment of disease by x-ray, radium or radioactive isotopes.

(6) Respiration Therapy is the treatment of dry or moist heat (and/or gases, including oxygen) into the lungs for therapeutic purposes.

(7) Speech Therapy is the treatment for the correction of a speech impairment resulting from disease, Injury, surgery, congenital and developmental abnormalities, or for previous therapeutic purposes.

Total Disability (Totally Disabled) means:

In the case of an Active Employee, as the result of an Injury or Sickness, the complete inability to perform any and every duty of their occupation or of a similar occupation for which the person is reasonably capable of performing, accounting for their education, training and experience.

In the case of a Dependent or Retired Employee, it means the complete inability as the result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Trustees (as applicable) refers to the Board of Trustees established pursuant to the bylaws of a joint insurance fund to govern or manage the risk management programs, joint self-insurance fund or funds and related services of the group.

Usual and Reasonable Charge/Fee (the Fund's rate schedule as may be applicable to this Plan) is the basis of payment by this Plan for various services provided to a Covered Person. Generally, this term shall refer to charges for services or supplies:

(1) Which is not higher than the usual charge made by the provider of the care or supply; and

(2) Does not exceed the usual charge made by

  (a) a certain percentage of the providers in the same area; or

  (b) most providers of like service in the same area

(3) The Plan Administrator, in its discretion, shall determine the usual and reasonable level of charges. Such determination shall be made in good faith and on a reasonable basis. This determination may also consider the nature and severity of the condition being treated, and may also consider medical complications or unusual circumstances that require more time, skill or experience.

SECTION VI
CLAIM AND PAYMENT INFORMATION
HOW TO SUBMIT A CLAIM
WHEN CLAIMS SHOULD BE FILED
CLAIM DENIAL AND NOTIFICATION
CLAIMS REVIEW PROCEDURE
APPEALING A CLAIM

SECTION VI

CLAIM AND PAYMENT INFORMATION

PAYMENTS FOR HOSPITAL BENEFITS

Payment for covered Hospital benefits is as follows:

(1) in a Hospital. For inpatient or outpatient services covered under this Plan.

(2) This Plan provides payments to Hospitals operated by the United States government only if:

(i) services are for treatment on an emergency basis; or

(ii) services are provided in a Hospital located outside of the United States and Puerto Rico

WHOM THIS PLAN WILL PAY

Facilities may submit a Covered Person's claim directly to the Claims Processing Company. After approval of the Covered Person's claim, payment will be made.

This Plan provides payment to Hospitals directly for inpatient claims. If a Covered Person is admitted as an outpatient, this Plan provides reimbursements to either the provider or the Covered Person for eligible expenses.

Note: Some Hospitals outside of New Jersey will bill directly. This Plan provides payment to the Hospital for eligible services up to the amount payable under this Plan.

If the Covered Person pays a facility for services covered under this Plan, reimbursement may be made directly to the Covered Person for the amount required be paid to the provider. All itemized bills should be forwarded to the Claim Processing Company **(Refer to "HOW TO SUBMIT A CLAIM")**.

PAYMENT FOR MEDICAL BENEFITS

Providers participating with this Plan as well as many other providers may submit a Covered Person's claim directly to the Claims Processing Company. After approval of the Covered Person's claim, payment will be made

This Plan provides payment directly to a provider participating under this Plan, or directly to a provider or to the Covered Person for the services rendered **(Refer to "HOW TO SUBMIT A CLAIM")**.

If, for any reason, the claim a Covered Person submits to the Claim Supervisor/ Processing Company is not eligible, the Covered Person will be notified of this within ninety (90) days of receipt of the claim. To request a review of the claim, a Covered Person should follow the instructions described in the "Claims Appeal" section of this Plan.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

(1) Obtain a claim form from the Personnel Office or the Plan Administrator.

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

(3) Have the Physician complete the provider's portion of the form.

(4) For expediting claim processing and Plan reimbursement, all claims must be submitted and accompanied by a completed, ***signed*** claim form and full size (8.5" x 11") itemized bills illustrating the following:

- Name of the Plan
- Group number of the Plan (if applicable)
- Employee's name
- Name of patient
- Name, address, telephone and tax identification number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Bills for the services of private duty nurses must show that the nurse is either a Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N.). The nurse's license number must be included, as well as a letter from the attending Physician certifying that the nursing services were Medically Necessary and not provided for the convenience of the Covered Person/patient or the family.

(6) Bills for prescription drugs must also show the name of the Covered Person/patient, the prescription number, the name of the prescription drug, and the quantity of the drug that was dispensed.

(7) If payment has been made by any other source (including **Medicare**), for any of the expenses being submitted for payment under this Plan, a Covered Person must include a copy of the explanation of benefits from the carrier along with the claim submission and itemized bills.

(8) Send the above information to the Claims Supervisor at the appropriate address as follows:

Horizon Blue Cross Blue Shield
P.O. Box 1609
Newark, NJ 07101
Claim Inquiries call: 800-355-2583

WHEN CLAIMS SHOULD BE FILED

Benefits are based on this Plan's provisions at the time the changes were incurred. Charges are considered incurred when a treatment or care is given or a procedure performed. Claims should be filed with the Claims Supervisor within ninety (90) days of the date charges for the service were incurred. Claims filed later than that date may be declined **unless**:

(1) It's not reasonably possible to submit the claim in that time; and

(2) The submission was made as soon as possible under the circumstances.

Except in the absence of legal capacity, in no event will an expense be considered if proof of the expenses and/or charges is submitted more than one (1) year after the date the expenses/charges were incurred. In no event will a claim for any expenses/charges be considered eligible which has been submitted beyond the one (1) year period following the conclusion of that Fund Year.

The Claims Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

CLAIM DENIAL AND NOTIFICATION

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Supervisor will furnish this Plan Participant with a written notice of the denial. This written notice will be provided within ninety (90) days after receipt of all information required to process the claim. The written notice will contain the following information:

(1) the specific reason or reasons for the denial;

(2) the specific reference to those Plan provisions on which the denial is based;

(3) description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Supervisor shall send written notice of the extension to the Plan Participant. The extension notice will indicate the circumstances requiring the extension of an additional ninety (90) days at which time this Plan expects to render a decision on the claim.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the Plan Participant to:

(1) Request from the Plan Administrator a review of any claim payment. Such request must include: the name of the Employee, his or her Social Security Number, the name of the patient and the Group Identification Number, if any.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Supervisor within sixty (60) days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator. The Plan Administrator will provide the Plan Participant with a written response within sixty (60) days of the date the Plan Administrator receives the Plan Participant's written request for review. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within sixty (60) days, the Plan Administrator shall notify the Plan Participant of the delay within the sixty (60) day period and shall provide a final written response to the request for review within one hundred twenty (120) days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall, if the denial is upheld, cite the specific Plan provision(s) upon which the denial is based.

APPEALING A CLAIM

(1) The Fund shall comply with the requirements of N.J.S.A. §17B:30-13.1 and 13.2.

(2) If the Plan Participant is dissatisfied with the determination of the claim processor, the Plan Participant may appeal the processor's determination to the Claims Supervisor and Service Company's ("TPA") Management Review Team who shall notify the Plan Participant in writing of their determination. The Plan Participant shall, at the time, be advised that the determination may be appealed to the Fund Commissioners and that, at the Plan Participant's written request, the appeal may be made with the identity of the Plan Participant and the Local Unit Employer revealed. Otherwise, the identity of the Plan Participant and the Local Unit Employer shall remain confidential. A copy of this communication with the Plan Participant's and Local Unit Employer's name deleted will be sent to the Executive Director.

(3) The Plan Participant may appeal an adverse determination concerning a claim to the Fund Commissioners by forwarding a copy of the determination letter issued by the Claims Processing Company ("TPA") to the Executive Director who shall place it on the agenda for a closed session determination at the next regularly scheduled meeting of the Fund Appeals Hearing Committee, unless the appeal is received seven (7) days or fewer prior to the next meeting, in which case it shall be listed on the ensuing meeting agenda. Prior to distribution of any writing concerning this appeal, all reference to the Plan Participant or the Local Unit

Employer shall be stricken, unless otherwise requested in writing by the Plan Participant. The Executive Director shall review the claim and make a written recommendation to the members of the Committee prior to their deliberation regarding the appeal. The Plan Participant may attend the closed session and/or may be represented at the meeting, provided that the Plan Participant has executed a Waiver of Confidentiality Form provided by the Fund in advance of the meeting designating the representative who shall also execute a Confidentiality Agreement. The Committee shall render its decision upon conclusion of the deliberations and advise the Plan Participant or Representative at that time, and confirm the determination in writing with the reasons therefore within five (5) days thereafter. If the Plan Participant or Representative is not present, notice of the Final Determination of the Committee shall be provided in writing with the reasons therefore within five (5) days thereafter.

(4) If the Plan Participant is dissatisfied with the determination of the Appeal Hearing Committee, the Plan Participant may appeal the Committee's determination to the independent appeal organization designated by the Fund at no cost to the Plan Participant, except that the Plan Participant shall be responsible for any legal fees and costs should the Plan Participant decide to be represented by counsel. Notice of such appeal shall be provided in writing to the Fund Executive Director within thirty (30) days of receipt of the written Committee determination. The proceeding before the independent appeal organization shall be arbitration before a single arbitrator governed by the laws of New Jersey.

SECTION VII
COORDINATION OF BENEFITS
THIRD PARTY RECOVERY PROVISION
COBRA CONTINUATION OPTIONS
RESPONSIBILITIES FOR PLAN ADMINISTRATION

SECTION VII

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits refers to the set of rules used when two (2) or more plans cover charges incurred by a Covered Person. These rules determine which plan should pay first, then second, etc. These situations arise when a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's covered Dependent children are covered under two (2) or more plans.

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

Benefit Plan

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

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

(6) No Fault Auto Insurance, or Out-of-State Automobile Insurance Coverage (OSAIC), by whatever name it is called, when not prohibited by law.

Allowable Charge

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will consider as an Allowable Charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Allowable Expenses

Means any necessary, Usual and Reasonable Expenses incurred while eligible for benefits under this Plan, part or all of which would be payable under any of the plans coordinated with this one.

The Plan Supervisor has the right to release to, or obtain from, any other organization or person, any information necessary for the administration of this provision.

When seeking benefits under this Plan, a Covered Person must furnish the Plan Supervisor information about other coverage which may be involved in applying this coordination provision.

Automobile Limitations

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

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

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

When Middlesex County is selected as the secondary payer, this Plan will be liable for the deductible, coinsurance and eligible expenses not covered by PIP within the cap chosen by the insured and eligible expenses above the PIP cap to the same extent as any other service and subject to all of the applicable contract provisions and limitations.

The Middlesex County Joint Health Insurance Fund Health Care Plan is in full in compliance with the New Jersey Auto Insurance Reform Act (Fair Act) regulations.

In the event that this Plan paid benefits that are later found to be greater than the allowable charge(s), this Plan may recover the amount of the overpayment from the source to which it was paid in full compliance with the New Jersey Auto Insurance Reform Act (Fair Act) regulations.

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

Generally, benefits under this Plan are secondary to OSAIC coverage, which means that this Plan will pay benefits *after* OSAIC. However, if the OSAIC coverage contains a provision which makes it secondary or excess to this Plan, then this Plan will pay before the OSAIC. In cases when there is a dispute as to who pays first, this Plan will pay before OSAIC.

Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

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

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

(a) The benefits of the benefit plan that covers the person directly (that is, as an Employee, Member or Subscriber), "Plan A", (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent, "Plan B."

Special Rule: As a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, (i) If the person who is covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to the plan covering the person as a Dependent, "Plan B", and (iii) Medicare is primary to the "Plan A" (for example, the person is retired), THEN "Plan B" will pay before "Plan A".

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid-off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid-off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid-off or Retired Employee.

If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

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

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

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

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

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

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

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

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

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

(f) If there is a conflict after these rules have been applied, the benefit plan which has covered the person for the longer time will be considered first.

(g) If there is still a conflict in the coordination of benefits and none of the preceding rules determine which plan would be primary, the Allowable Expenses shall be shared equally between the plans.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

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

(5) The Balance Budget Amendment Act of 1997 permits Medicare beneficiaries the opportunity to contract privately with a Physician or other Provider for any service(s) and pay the Provider for all charges for such service(s) in full, but no claim for such services may be submitted to Medicare for reimbursement.

This Plan shall not consider, pay or reimburse for any service(s) rendered by a Physician or other Provider who enters into a private contract with a Medicare beneficiary which states

that the Medicare beneficiary will pay for all charges for such service(s) in full to the Physician or other Provider.

Claims Determination Period

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

Right to Receive or Release Necessary Information

This plan retains the authority and discretion to give or obtain needed information from other insurers, organizations or persons. This information may be given or obtained without the consent of or notice to any other person. As a condition of coverage, a Covered Person will provide this Plan information regarding any and all other insurance coverage the Covered Person has, including (but not limited to) policy numbers, dates of coverage and payment of Allowable Charges.

Facility of Payment

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

Right of Recovery

In the event that this Plan paid benefits that should be paid by another benefit plan, this Plan may seek reimbursement. In such cases, this Plan may recover the amount incorrectly paid from the other benefit plan or from the Covered Person. That repayment will count as a valid payment under the other benefit plan.

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies

A Covered Person may incur medical or dental charges due to injuries caused by the act or omission of a third party and/or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges.

Reimbursement/Refund Rights

As a condition of receiving benefits under this Plan, a Covered Person automatically assigns and transfers to this Plan any rights the Covered Person may have to recover payments from any third party or insurer (including, but not limited to such Covered Person's own insurer(s)), for funds paid

or payable under this Plan as a result of personal injury or reimbursement of medical expenses. Further, in the event the Covered Person receives any funds from a judgment, settlement or otherwise from any other person, business entity or any other source, the Covered Person shall first repay this Plan in full as the first priority party, for any benefits paid by this Plan.

Subrogation Rights

As a condition of receiving benefits under this Plan, a Covered Person recognizes, transfers, conveys and otherwise authorizes this Plan to directly pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person or Dependent chooses to pursue that claim.

Plan's Priority Over Funds

The Covered Person agrees to recognize this Plan's right to subrogation and reimbursement. These rights provide this Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. This priority shall be enforceable even if the Covered Person is not made whole by the available recoveries, and shall be considered a lien against such recoveries until this Plan is repaid in full.

Amount Subject to Subrogation or Refund

This Plan's priority to funds, subrogation and refund rights, and any/all rights assigned to it, is limited to the extent to which this Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under this Plan.

Agreement to Assist In Enforcing Rights

Covered Person(s) under this Plan agree to: (1) inform this Plan in writing within sixty (60) days of their claim against third parties, entities and/or insurers for benefits; (2) furnish information and assistance regarding the existence and status of such claims; and (3) execute any documents as this Plan may require to enforce its rights under this Plan. Covered persons also agree to take no action which may prejudice the rights or interest of this Plan under this Plan Document.

Failure to comply with these provisions will be considered a material breach of this Plan Document and may result in the Covered Person(s) being personally responsible for reimbursing this Plan, and/or lead to a denial of all further Plan benefits.

COBRA CONTINUATION OPTIONS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator (who is responsible for administering COBRA continuation coverage) to Plan Participants who become eligible for COBRA continuation coverage

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must also complete a universal benefits form and submit such form to the Personnel Department within 60 days after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to18 months.

As explained below, there are two ways in which this 18-month period of COBRA continuation coverage can be extended:

(1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the

determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the COBRA Administrator.

(2) Second qualifying event: extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EXTENSION OF MEDICAL EXPENSE COVERAGE

If the conditions below are met, a person's protection under the coverage will be extended after the date that person ceases to be a Covered Person.

Conditions

(1) The person ceased to be a Covered Person for reasons other than:

(a) Exhaustion of a Lifetime overall benefit maximum; or

(b) Failure of the Employee to make a required contribution.

(2) On that date the person ceased to be a Covered Person, the person is:

(a) Totally Disabled form a Sickness or Injury; and

(b) Under a Physician's care.

If the extension applies, it is only for that or any related Sickness or Injury. It will be for the time the person remains so disabled under any such Sickness or Injury and under such are, but not beyond the time limit shown below.

During the extension, the provisions of coverage will apply as if the person were still a Covered Person. There is one (1) exception:

(1) There will be no automatic restorations of part or all of the Lifetime benefit maximum.

Time Limit

Benefits will be provided to the end of the Calendar Year after the one in which the person ceases to be a Covered Person.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR AND ITS DUTIES

Plan Administrator

Middlesex County Joint Health Insurance Fund ("Fund") Health Care Plan is the benefit plan of the Plan Sponsor. It is to be administered by the Fund, as the Plan Administrator, in accordance with the provisions of N.J.S.A. §40A:10-36 *et. seq*.

The Plan Administrator shall administer this Plan in accordance with the Fund-By-Laws and Risk Management Plan, or as approved by the State of New Jersey Department of Insurance pursuant to N.J.S.A. §40A:10-36 *et. seq.*

Service of legal process may be made upon the Plan Administrator.

Duties of this Plan Administrator

The following are the duties of the Plan Administrator:

(1) To administer this Plan in accordance with its terms.

(2) To interpret this Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain this Plan's document and all other records pertaining to this Plan.

(6) To appoint a Claims Supervisor to pay claims.

(7) To perform all necessary reporting.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Claims Supervisor is NOT a fiduciary

A Claim Supervisor is not a fiduciary under this Plan by virtue of paying claims in accordance with this Plan's rules as established by the Plan Administrator.

FUNDING THIS PLAN AND PAYMENT OF BENEFITS

Cost of this Plan

The cost of this Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer for Active Employees (and eligible Dependent(s)) who fulfill the eligibility requirements of the Plan Sponsor, unless otherwise stipulated in individual collective bargaining unit and/or Plan Sponsor contractual agreements.

For Retired Employees and Dependant Coverage: Funding is derived solely from the funds of the Retired Employees (and eligible Dependent(s)) who directly retire under the criteria of and participate in a State of New Jersey administered retirement system who fulfill the eligibility requirements of the Plan Sponsor in accordance with certain collective bargaining unit agreements.

Benefits are paid directly from this Plan through the Claims Supervisor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

This Plan

This Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Handling a Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, this Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.