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AGREEMENT

BETWEEN

THE BOROUGH OF RUTHERFORD

AND

THE RUTHERFORD DEPARTMENT HEADS UNIT

March 20, 2015

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PREAMBLE

THIS AGREEMENT made as of the day of , 2015, by and between the Borough of Rutherford a municipality in the County of Bergen and State of New Jersey, hereinafter referred to as the "Borough" and the RUTHERFORD DEPARTMENT HEADS UNIT, and hereinafter referred to as the "Unit", represents the complete and final understanding on all bargainable issues between the Borough and the Unit.

PURPOSE

WHEREAS, the Borough and the Unit recognize that it will be to the benefit of both to promote mutual understanding and foster a harmonious relationship between the parties to the end that continuous and efficient service will be rendered to and by both parties,

NOW THEREFORE, it is agreed as follows:

ARTICLE I

RECOGNITION

A. The Borough recognizes the Unit as the exclusive collective bargaining agent for the purpose of collective negotiation with respect to the negotiable terms and conditions of employment for the below enumerated Department Heads, Borough of Rutherford, Bergen County, New Jersey. Attached hereto as Appendix A is a list of all titles covered by this Agreement. Recognition of the Unit is in accord with the Stipulation of Settlement entered into between the Borough and the Unit dated October 21, 1985.

B. Whenever the term "Employee or Employees" is used herein it shall be construed to mean those employees covered by this Agreement.

C. There shall be no discrimination, interference, or coercion by the Borough or any of its agents against the employees represented by the Unit because of membership or activity in the Unit. The Unit or any of its agents shall not intimidate or coerce employees into membership. Neither the Borough nor the Unit shall discriminate against any employee because of race, creed, color, age, sex or national origin.

D. No employee shall be compelled to join the Unit but shall have the option to voluntarily join said Unit.

E. It is hereby recognized and agreed that an employee shall have the right to withdraw from membership in the Unit, said withdrawal shall only be permitted on January 1 or July 1. In the exercise of that right, neither party, nor any of its agents shall discriminate, coerce or otherwise interfere with the employees.

F. The Borough will notify the Unit within three (3) days of hire of all employees, job classification, rate of pay, and of all removals of employees from the Borough's payroll.

ARTICLE II

DUES CHECK-OFF

Payroll deductions for dues may be made upon the submission by the Unit of notification by the employee authorizing the deduction of dues from pay. The Borough Chief Financial Officer shall forward dues to the Unit representative (which said representative shall be confirmed by written authorization of the Unit) once during each 3-month period. Employees shall have the right to withdraw authority for deduction of dues in accordance with New Jersey State Statutes.

ARTICLE III

UNIT REPRESENTATIVES

A. The Borough recognizes the right of the Unit to designate two (2) representatives for the enforcement of this Agreement. The Unit shall furnish the Borough in writing the names of the representatives and notify the Borough of any changes.

B. The authority of the representatives so designated by the Union shall encompass the following duties and activities:

1. The investigation and presentation of grievances in accordance with the provisions of the collective bargaining Agreement; and

2. The transmission of such messages and information which shall originate

with, and are authorized by the Union or its officers.

C. Only one (l) designated Union representative shall be granted time with pay during work hours to investigate and seek to settle grievances or to attend meetings and conferences on said grievances with Borough officials, provided prior arrangements are made with the Borough Administrator or his or her designated representative and provided further that Borough operations are not interrupted.

ARTICLE IV

CONDUCTING UNIT BUSINESS

A. No Unit member or officer or authorized representative shall conduct any Unit business on Borough time except as specified in this Agreement.

B. No Union meetings shall be held on Borough time or use Borough facilities unless specifically authorized by the Borough in writing. The Borough agrees to provide a meeting facility after working hours at least once a month (if requested) provided arrangements are made in advance in writing and rooms are available.

C. Only two (2) authorized representatives may confer with management on grievances or other matters of mutual interest.

D. The Borough agrees that it will permit one of the authorized representatives to take a reasonable amount of time from the job to confer with management on, or to investigate grievances without loss of pay, provided prior arrangements to be excused are made with the Borough Administrator or designated representative.

E. The Borough reserves the right to deny the Unit representative permission to conduct Unit business on Borough time as outlined in this Article if said activity interferes with the Borough's operations.

ARTICLE V

BULLETIN BOARD

A. The Borough will permit one enclosed bulletin board for the use of the Union to be placed in the employee lounge in the Borough Hall.

B. The bulletin board shall be for the use of the Unit for the posting of notices and bulletins pertaining to Unit business and activities or matters dealing with the welfare of employees.

C. No matter may be posted without receiving permission of the officially designated Unit representative. All items posted shall be on Unit letterhead.

D. In the event that material posted on the Unit bulletin board shall be deemed detrimental to the interests and operation of the Borough, then and in that event the Borough Administrator may remove such material.

E. No material of a derogatory, inflammatory, insulting or demeaning nature against the Borough, any employee and/or official of the Borough or any resident/citizen/landlord/tenant/business owners of the Borough shall be permitted to be posted.

ARTICLE V (A)

CAR/CLOTHING ALLOWANCES

A. The following Department Heads shall be entitled to use of Borough vehicles during work periods with all attendant costs assumed by the Borough:

(i) Construction Official
(ii) D.P.W. Superintendent
(iii) Fire Marshal

B. The following Department Heads shall be entitled to use of Borough vehicles for the purpose of commuting to and from work if the employee resides in the Borough of Rutherford, and use for work related activities during non-business hours:

(i) Construction Official
(ii) Fire Marshal
(iii) D.P.W Superintendent

C. The following Department Heads shall be entitled to a monthly car allowance in

the amount of $200.00:

(i) Recreation Director
(ii) Borough Clerk

The monthly car allowance referenced in paragraph C of this Article shall be paid to the applicable Unit members retroactive to the first day of the contract term. Any retroactive monies due unit members by virtue of this Article shall be paid as soon after execution and governing body approval as practicable.

D. Department Heads required to use their personal vehicles for work related activities shall be reimbursed at the current Internal Revenue Service approved rate of reimbursement.

E. The Borough agrees to provide a safe working environment wherein all known occupational hazards, including toxic material, are removed or remedied to the greatest extent practicable.

F. The Fire Marshal, the DPW Superintendant, and the Construction Official shall receive a clothing allowance of $600 from the signing of this agreement plus a $25.00 per year increase for each of the subsequent contract years.. .

_____G.Clothing allowance will be reimbursed to each employee with proof of payment submitted to the purchasing department. Employees may also submit a purchase order.
In order to qualify for the clothing allowance the Fire Marshal, the DPW Superintendant, and the Construction Official are subject to the following dress code:

- Pants - restricted to blue or beige khaki or cargo pants. Jeans are prohibited.
- Shirts – must have Borough and/or Department insignia. Short sleeve shirts must also have a collar.
- Shoes – must comply with all State/Federal requirement(s) that pertain to said position. Sneakers are prohibited.
- The Fire Marshall is exempt from the aforementioned dress code when wearing his uniform.

ARTICLE VI

COLLECTIVE NEGOTIATING PROCEDURE

A. Collective negotiations with respect to rates of pay, hours of work or conditions of employment shall be conducted by the duly authorized negotiating agents of each of the parties. Ordinarily not more than two (2) representatives of each party shall participate in collective negotiating meetings. Additional persons may be permitted upon mutual agreement of the parties.

B. Collective negotiating meetings shall be held at time and places mutually convenient at the request of either the Borough or the Unit in accordance with time frames stipulated by law or sooner if the parties agree.

C. In the event any negotiating meetings are scheduled during any part of the working day, employees of the Borough may be designated by the Unit to participate in such negotiating meetings. Up to a maximum of two (2) will be excused from their Borough work assignments by the Borough provided their absence will not interfere with the Borough's operations. The decision to excuse employees from their work assignments to participate in negotiations shall be in the sole discretion of the Borough Administrator or his or her designee.

D. The duly authorized negotiating agents of either the Borough or the Unit are not required to be an employee of the Borough.

ARTICLE VII

DISCRIMINATION AND COERCION

A. There shall be no discrimination, interference or coercion by the Borough or any of its agents against the employees represented by the Unit.

B. The Unit, or any of its agents, shall not intimidate or coerce employees into membership.

C. Neither the Borough nor the Unit shall discriminate against any employee because of race, creed, color, age, sex or national origin.

ARTICLE VIII

MANAGEMENT RIGHTS

A. The Borough hereby retains and reserves unto itself without limitations, all powers, rights, authority, duties and responsibilities conferred upon and vested in it prior to the signing of this Agreement by the Laws and Constitution of the State of New Jersey and of the United States, including, but without limiting the generality of the foregoing, the following rights:

1. To the executive management and administrative control of the Borough Government and its properties and facilities and the activities of its employees;

2. To hire all employees and subject to the provisions of law, to determine their qualifications and conditions for continued employment and assignment and to promote and transfer employees;

3. To suspend, demote, discharge or take other disciplinary action for good cause according to law.

B. In the exercise of the foregoing powers, rights, authority, duties and responsibilities of the Borough, the adoption of policies, rules, regulations and practices in furtherance thereof, and the use of judgment and discretion in connection therewith shall be limited only by the specific and express terms of this Agreement and then only to the extent such specific and express terms hereof are in conformance with the Constitution and Laws of New Jersey and the United States.

C. Nothing contained herein shall be construed to deny or restrict the Borough of its powers, rights, authority, duties and responsibilities as prescribed by law.

ARTICLE IX

GRIEVANCE PROCEDURE

A. To provide for the expeditious and mutually satisfactory settlement of grievances arising with respect to complaints occurring under this Agreement, the following procedures shall be used. For the purpose of this Agreement, the term "grievance" means an appeal by the Unit, and only by the Unit, on behalf of an individual employee or group of employees from the interpretation, application or violation of the terms and conditions of this collective bargaining agreement.

B. The procedure for settlement of grievances shall be as follows:

1. Step One

In the event that the Unit has a grievance, within four (4) working days of the occurrence of the event being grieved the Unit shall discuss it informally with the Borough Administrator. It is exclusively the province of the Unit and not that of an individual employee or a group of employees to grieve an event. The Borough Administrator shall decide the grievance within four (4) working days after the grievance is first presented to him and shall present said decision to the Unit in written form.

2. Step Two

If no satisfactory resolution of the grievance is reached at Step One, then within four (4) working days of the date the Borough Administrator decides the grievance, the grievance shall be presented in writing to the Mayor and Council. It is exclusively the province of the Unit and not that of an individual employee or a group of employees to grieve an event. The Governing Body shall render a decision within fifteen (15) working days after the grievance was first presented to it and shall present said decision to the Unit in written form.

3. Step Three

(a) If no satisfactory resolution of the grievance is reached at Step Two, then

within five (5) working days of the date the governing body decides the grievance, the grievance shall be referred to PERC (Public Employees Relations Commission)for the selection of an Arbitrator. It is exclusively the province of the Unit and not that of an individual employee or a group of employees to refer a grievance event to PERC. The decision of the Arbitrator shall be final and binding upon the parties. The expense of such arbitration shall be borne equally by the parties.

(b) The arbitrator shall have no authority to add to or subtract from the Agreement.

(c) It is agreed between the parties that no arbitration hearing shall be held until after the expiration of at least thirty (30) days after the decision rendered by the Mayor and Council on the grievance. Further, it is the intent of the parties that no matter in dispute that is subject to the review and/or the decision of the New Jersey Civil Service Commission may be submitted to arbitration. The parties herein direct the Arbitrator not to accept or to decide any matter in dispute that is subject to New Jersey Civil Service Commission review and decision.

(d) If a decision is not rendered within the time limits prescribed for such a decision at any step in the grievance procedure, then it shall be deemed to have been denied.

(e) The time limits expressed herein shall be strictly adhered to. If any grievance has not been initiated within the time limits specified, then the grievance shall be deemed to have been abandoned. If any grievance is not processed to the next succeeding step in the Grievance Procedure within the time limits prescribed, then the disposition of the grievance at the last preceding step shall be deemed to be conclusive. Nothing herein shall prevent the parties from mutually agreeing to extend or contract the time limits provided for processing the grievance at any step in the Grievance

Procedure.

(f) Working days shall be defined throughout this Article as Monday through Friday irrespective of whether or not the employee works those days.

(g) Attendance at a grievance or arbitration hearing or matter by anyone other than the grievant and his or her Unit representative shall be permitted only by subpoena, and only if the individual subpoenaed is testifying. No overtime shall be paid for attendance at a grievance or arbitration.

ARTICLE X

DISCHARGE AND DISCIPLINE

A. No employee shall be disciplined arbitrarily or without reason. The Borough shall notify the Unit at the time if disciplinary action is taken.

B. A grievance by an employee claiming that he has been unjustly discharged or suspended must be submitted in accordance with the grievance procedure outlined in Article IX unless the subject grievance is subject to the jurisdiction of the New Jersey Department of Personnel in which case the procedures therein shall apply.

C. Any employee whose appeal has been sustained shall be returned to his former position and compensated at his regular rate for any time lost during the period of such dismissal.

D. The provision shall be construed and interpreted to be consistent with the Civil Service laws, rules and regulations.

ARTICLE XI

WAGES

A. The rates of pay for each job classification in the Department Heads Unit are set forth in Appendix B attached hereto and made a part hereof.

B. The base annual salary guide shall be retroactive to the first day of the contract term. Any retroactive monies due employees by virtue of this clause shall be paid as soon

after execution of this Agreement as practicable.

C. Entitlement to salary increments shall accrue as of January 1 of each year and be paid retroactively to that date after adoption of the Municipal Budget and Salary Ordinance for that year. However, new employees hired after June 30th of any year shall not be entitled to any increment until January 1st of the second year of their employment.

ARTICLE XII

LONGEVITY

A. Each employee shall be paid, in addition to his/her base pay, a longevity increment based upon years of service in the employ of the Borough in accordance with the following schedule:

Employees Hired on or prior to December 31, 1990

YEARS OF SERVICE	INCREMENT OF BASE PAY
Upon completion of 5 years service	1%
Upon completion of 10 years service	3%
Upon completion of 15 years service	5%
Upon completion of 20 years service	7%
Upon completion of 24 years service	9%

Employees Hired after January 1, 1991 but on or prior to December 31, 1997

YEARS OF SERVICE	INCREMENT OF BASE PAY
Upon completion of 5 years service	$ 400
Upon completion of 10 years service	$1,200
Upon completion of 15 years service	$2,000
Upon completion of 20 years service	$2,800
Upon completion of 24 years service	$3,600

B. Longevity increments shall be effective on July 1 or January 1 following the anniversary date of employment.

C. Longevity pay will be eliminated for any employees hired after January 1, 1998. However, any person currently employed by the Borough who becomes a member of the unit, by promotion or otherwise, shall receive longevity based on their original date of hire.

ARTICLE XIII

HOLIDAYS

A. The following days are designated as paid holidays for all full time employees covered by this Agreement:

New Year's Day

Martin Luther King Day

President's Day

Good Friday

Memorial Day

Independence Day

Labor Day

Columbus Day

Veteran's Day

Thanksgiving Day

Day after Thanksgiving

1/2 day on Christmas Eve*

Christmas Day

1/2 day on New Year's Eve*

B. In the event any of the aforementioned holidays shall fall on a Saturday, it shall be celebrated on the Friday immediately preceding it; and in the event any of the aforementioned holidays shall fall on a Sunday, it shall be celebrated on Monday immediately following it. In the event that Christmas Eve or New Years Eve fall on a Sunday, the ½ day will be taken an the preceding Friday.

C. Holidays falling within a period of approved paid absence will entitle the employee to be paid for such holidays. Periods of approved paid absence are sick leave, injury leave, terminal leave, jury duty leave, vacation leave and funeral leave.

D. Employees are required to work the last day prior to the holiday and the first workday following the holiday in order to be paid for the holiday unless their absence is excused or waived by the Borough Administrator in accordance with established Borough policy. The Borough Administrator shall not unreasonably withhold his consent in this regard.

E. Holidays falling during an unpaid leave of absence will not be credited.

*In the event that this holiday falls on a weekend, then and in that event, the employees shall be entitled to receive the day before the actual holiday.

ARTICLE XIV

VACATIONS

A. Subject to Civil Service Laws, Rules and Regulations when applicable and consistent with existing practice, employees shall be granted the following annual leave for vacation purposes with pay:

EXISTING EMPLOYEES
("Existing Employees" is defined as an Employees currently holding a position as Department Head at the time of the signing of this contract)

1st Year	1 Working day per month
Years 2 – 4	16 Working days
Years 5-9	19 Working days
Years 10-14	21 Working days
Years 15-19	24 Working days
Years 20-24	27 Working days
Years 25 +	30 Working days

INTERNAL PROMOTIONS
("Internal Promotion" is defined as an employee promoted from within the Borough after the execution date of this contract)

1st Year	1 Working day per month
Years 2 – 5	15 Working days
Years 6-10	19 Working days

Years 11-20	22 Working days
Years 21 +	25 Working days

Note: Vacation days can never be less than days received in previous position

NEW HIRES
("New hire" is defined as a Department Head hired from outside of the Borough who is not currently working as a Borough employee at the time they are hired)

1st Year	1 Working day per month
Years 2-10	15 Working days
Years 11-19	18 Working days
Years 20 +	20 Working days

B. New employees in their first year of service will be permitted to take their vacation leave as earned.

C. Beginning January 1 of each successive year of employment, employees shall be permitted to use in advance of earning the full amount of vacation leave for that year. Any vacation time "borrowed" under this policy must be earned back by the last pay period of that calendar year. If this is not done and a negative vacation balance results, it will be deducted from the employee's pay. In the event of termination of employment prior to repayment of advanced vacation leave, the necessary salary adjustments will be made on the employee's final paycheck.

D. Earned vacation leave for one (1) calendar year may be carried to the following year. The request shall be presented by each Unit member to the Borough Administrator in writing, be carried over and used during the following calendar year and only during the following calendar year. In the event that vacation time is not utilized one year after the year within which it is earned, the said vacation time not utilized shall lapse. Any requests in writing to carry over vacation days in accordance with this Article shall be submitted to the Borough Administrator on or before November 30 of each year of the term of this contract. Such requests shall not be unreasonably denied by the Borough Administrator, however in all instances, the necessities of the effective operations of the applicable Department and of the Borough shall be weighed in the Borough Administrator's decision making.

E. If an employee resigns with proper notice or plans to retire, the employee shall

be entitled to earned and unused vacation leave as of the effective date of termination.

F. If an employee shall die while employed, a sum of money equal to earned and unused vacation leave shall be paid to his estate.

G. The salary paid to an employee while on vacation leave will be the same amount the employee would have earned while working regular straight time hours during vacation.

H. Employees on approved, paid vacation leave will continue to accrue vacation leave according to length of service and regular work schedule.

I. If a holiday observed by the Borough occurs during the period of the employee's vacation leave, it is not charged against the balance of the employee's vacation leave and an equivalent day off shall be granted.

J. Employees shall receive their salary covering the period of vacation prior to commencing vacation to the extent that they have earned and accrued such vacation time and providing that at least a one-week vacation is to be taken, and the employee has notified the Borough Administrator in writing at least fifteen (15) days prior to the commencement of the vacation.

K. If an employee is on vacation and becomes sufficiently ill so as to require in-patient hospitalization, he may have such period of illness and post hospital recuperation period charged against sick leave at his option upon proof of hospitalization and a physician's certificate.

L. Any vacation leave, which exceeds two (2) days in time, shall be submitted to the Borough Administrator for review and approval. The approval of the Borough Administrator in this regard shall not be unreasonably withheld.

ARTICLE XV

HOURS OF WORK

A. The standard weekly work schedule for all full time employees shall consist of thirty-five (35) hours from Monday through Friday. The basic workday shall consist of seven (7) hours per day, exclusive of a one-hour lunch period.

B. It is recognized by the parties that the regular office hours of the Borough Departments begin at 8:30 a.m. and end at 4:30 p.m., with the exception of SuperintendantofPublic Works who shall maintain hours in accordance with the DPW contract which is currently set at 7 a.m. to 3 p.m..Department heads shall make reasonable efforts to ensure that offices are properly staffed during regular office hours. In the event of office closure, notification shall be given to the Borough Administrator..

C. It is agreed and understood that special circumstances may, on occasion, dictate deviations from the hours and times of work set forth herein. In such cases the affected Unit employee shall make request in writing of the Borough Administrator of the special circumstances so that the Administrator may modify the regular schedule on a case-by-case basis.

D. It is agreed and understood that based upon their specific job responsibilities, Department Heads will be expected to be present and attend events, functions and/or emergencies including both scheduled events and unanticipated circumstances or emergencies, outside of the standard work schedule. This time shall be in addition to the standard weekly work schedule as defined herein.

E. In full consideration of their presence at all events, functions, and/or emergencies referenced and detailed in the preceding paragraph, members of the Unit shall receive, in addition to and exclusive of, wages as referenced herein in Article XI and in addition to and exclusive of longevity as applicable as referenced herein in Article XII thefollowing stipend or compensatory time:

Employee Stipends

Tier A	Current Employee	Prom. Emp.	O/S Hire
Fire Marshall	$4,500	$3,000	$2,000
DPW Supt.	$4,500	$3,000	$2,000
Const. Off.	$4,500	$3,000	$2,000

Tier B	Current Employee	Prom. Emp.	O/S Hire
Borough Clerk	$3,000	$2,000	$1,500
Rec. Dir./Supt.	$3,000	$2,000	$1,500

Tier C	Current Employee	Prom. Emp.	O/S Hire
Soc. Services Dir.	$2,000	$1,500	$1,000
Tax Collector	$2,000	$1,500	$1,000

G. The monetary stipends, and only the monetary stipends, referenced in the preceding paragraph of this Article shall be paid to the Unit members retroactive to the first day of the contract term. Any retroactive monies due Unit members by virtue of this Article shall be paid as soon after execution and governing body approval as practicable.

OUTSIDE EMPLOYMENT

Subject only to the Statutes of New Jersey applicable case law and the New Jersey Administrative Code, no employee shall be restricted or impaired from maintaining outside employment.

Any such outside employment, however, shall not interfere with the regular work hours or duties of the employee including those duties requiring a Departmental Head to be present and work outside the standard work week as specified in paragraph E of this Article.

MAINTENANCE OF WORK OPERATIONS

The parties agree that there shall be no lockouts, strikes, work stoppages, job actions, or slowdowns during the life of this Agreement. No officer or representative of the Association shall authorize, instigate, or condone such activity, nor shall any employee participate in such activity.

It is understood that violation of the provisions of this Article may subject any

employee participating in or condoning such activity to disciplinary action by the Borough. Such disciplinary action may include termination of employment or any other appropriate lesser form of discipline.

ARTICLE XVI

COMP PLAN

The employer shall take appropriate action to analyze and potentially establish an Employee Deferred Compensation Plan approved by the Internal Revenue Service and in conjunction therewith will use its best efforts to offer Borough employees such benefits, which plan, shall be on a total employee contribution basis.

ARTICLE XVII

MEDICAL COVERAGE

A. Effective January 1, 2012, each member of the Bargaining Unit plan covered by the Borough's medical plan shall make contributions in accordance with New Jersey State Law Chapter 2 P.L. 2010 dated May 21, 2010 and P.L. 2011 Chapter 78, dated June 28, 2011. Any employee may opt out and receive a cash payment from the Borough in the amount of 25% of the premium or $5,000.00 whichever is less.

A copy of the current medical plan shall be attached to this contract as Appendix C. A copy of the prescription plan shall be attached to this contract as Appendix D. A copy of the dental plan shall be attached to this contract as Appendix E.

B. The Borough will provide and pay for health insurance for employees and their eligible dependents covered by this Agreement who work twenty-five (25) or more hours per week. The Borough shall provide a coverage plan with equivalent benefits as currently offered. The plan shall be substantially the same coverage as the plan currently in place and provided under the addendum agreement to the prior collective bargaining agreement between the parties dated August 11, 2010 as to benefits and usual and customary fees.

C. The Borough shall have the option of securing equivalent coverage from an insurance company of its choosing.

D. Effective May 21, 2010, in accordance with Chapter 2 of P.L. 2010, all members of the bargaining unit shall be required to pay a contribution equal to 1.5% of their pensionable based salary or health care coverage.

Effective June 28, 2011, all members of the bargaining unit shall no longer be governed by Chapter 2 P.L. 2010, and shall hereafter be governed by the provisions of Chapter 78 P.L. 2011 and all provisions therein. The Borough shall provide retiree medical, prescription and dental coverage to members of the bargaining Unit retiring with twenty-five (25) or more years of service to the Borough who retire on or after July 2, 2006 as follows:

1. Said insurance will be provided to each employee(s), who shall submit proof of statement from the Public Employees Retirement System (PERS), including a copy of the first pension check (endorsed) and the bank deposit slip.
2. The retiree and spouse shall be covered (if the employee is married before the date of retirement) for the lifetime of the retiree and spouse, unless the spouse has insurance coverage as set forth below.
3. If the retiree is not eligible for any other dental insurance from any other employer or from the retiree's spouse.
4. If the retiree or spouse should remarry after the death of the retiree or spouse, the benefit coverage shall not extend to the new partner.
5. If the retiree retires on or after July 2, 2006 as per this section, the employee/retiree and spouse shall be responsible to pay twenty-five (25%) percent of the Borough's yearly premium costs for such coverage for the lifetime of the retiree or spouse.

E. The Borough shall provide a full-family dental plan covering employees and their dependents. The plan which shall be implemented is set forth as Appendix Eto this

Agreement. The Borough shall bear the full cost of the plan. The Borough shall have the option of securing equivalent coverage from another insurance company. The Unit shall be advised of any such decision and shall be given a copy of all such insurance information.

F. Eyeglasses - The Borough, if requested by the Unit, shall implement the same type of payroll withholding procedure which it has established for the Borough Police Department in regard to an eyeglass program, but the total cost of same shall be paid for by the employee. The Borough shall only be required to administer such program.

G. Prescription –The Borough will provide a prescription plan for employees and their eligible dependents covered by this Agreement who work twenty-five (25) or more hours per week. The Borough shall provide a prescription coverage plan with equivalent benefits as currently offered. The plan shall be substantially the same coverage as the plan currently in place and provided under the addendum agreement to the prior collective bargaining agreement between the parties dated August 11, 2010.

H. If desired by the Unit, the Borough agrees to implement a Section 125 Flexible Spending Account Plan pursuant to the provisions of federal law.

ARTICLE XVIII

SICK LEAVE

A. All permanent full time employees covered by this agreement shall be granted sick leave with pay of one (l) working day for every month of service during the remainder of the first calendar year of service and fifteen (l5) working days (l l/4 per month) in each calendar year thereafter which shall accumulate from year to year. If the employee begins work after the tenth of the month, sick leave is not earned for that month.

B. Sick leave with pay is hereby defined to mean a necessary absence from duty due to illness, injury or exposure to contagious disease and may include absence due to illness in the immediate family of the employee or necessary attendance upon a member of the immediate family. Immediate family shall include spouse, children, parents, brothers,

sisters and grandparents of employee or spouse.

C. Sick leave must be earned before it can be used except that the employer (Borough) may grant sick leave in advance on a case-by-case basis. Should the employee require none or only a portion of the earned sick leave for any year, the amount not taken accumulates to the employee's credit from year to year during employment.

D. In order to receive compensation while absent on sick leave, the employee shall notify the Borough Administrator or his or her designee no later than fifteen (15) minutes after the time set for him/her to begin his/her daily work schedule. Failure to so notify the Borough Administrator may be cause for denial of the use of sick leave for that absence and constitute cause for disciplinary action. It is agreed, however, that unusual circumstances will be considered on a case-by-case basis. Any employee who is absent more than five (5) days without notice to the Borough is subject to dismissal in accordance with Civil Service Law.

E. A sick day shall be charged for an absence of more than three and one-half (3 ½) hours or one-half (l/2) day for an absence of less than three and one-half (3 ½) hours. The minimum amount of time charged for sick leave is one-half (1/2) day and sick leave shall be charged in one-half (1/2) day increments.

F. The Borough may require medical proof of illness of an employee or a member of the employee's immediate family as referenced in paragraph B of this Article.

G. The Borough reserves the right to require a doctor's note at any time at the Borough's expense. All records from any such examination shall be the property of the Borough and the Unit employees shall sign all necessary releases, including, but not limited to, a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") release, to allow the Borough to obtain such records. Failure of a Unit employee to comply with this provision shall be cause for disciplinary action.

H. Abuse of sick leave shall be cause for disciplinary action.

ARTICLE XIX

TERMINAL PAYMENT

A. Upon an employee's regular retirement, disability retirement or resignation or death, the employee shall be entitled to time off or to compensation for accumulated, unused sick leave as follows:

Existing Department Heads

(1) Fifty percent (50%) of all remaining accumulated sick days after twenty years of service subject to a maximum amount of $10,000.00

(2) Seventy-five percent (75%) of all remaining accumulated sick days after twenty-five years of service subject to a maximum amount of $15,000.00

Employees Promoted from Within and New Hires

(1) Fifty percent (50%) of all remaining accumulated sick days after twenty years of service subject to a maximum amount of $7,500.00

(2) Seventy-five percent (75%) of all remaining accumulated sick days after twenty-five years of service subject to a maximum amount of $10,000.00

B. Terminal payment due to an employee who dies shall be paid to the estate of said employee.

D. Any Unit employee that is separated from service for a cause arising from any disciplinary action shall not be entitled to compensation for accumulated leave.

ARTICLE XX

PERSONAL DAYS

A. An employee shall be entitled to four (4) personal days off with pay each year to be used as the employee sees fit. One of said personal days shall be chargeable against sick leave and three (3) shall be non-chargeable. At least one (1) day's notice shall be given to the Borough Administrator that the employee intends to take his or her personal day.

B. A personal day shall be charged for an absence of more than three and one-half (3 ½) hours or one-half (1/2) day for an absence of less than three and one-half (3 ½) hours.

The minimum amount of time charged for personal leave is one-half (1/2) day and personal leave shall be charged in one-half (1/2) day increments.

C. The personal days provided for herein shall not be accumulated for use in succeeding years.

ARTICLE XXI

LEAVE OF ABSENCE

A. Any full time employee covered by this Agreement may take a leave of absence without pay from Borough duties, if recommendation therefore is given by the Borough Administrator or designated representative and the Mayor and Council grant approval in accordance with all applicable Federal and State law.

ARTICLE XXII

FUNERAL LEAVE

A. All permanent full time employees covered by this Agreement shall be entitled to up to three (3) consecutive working days leave with pay one of which shall be either the day of death or the day of the funeral, whichever the employee chooses upon the death of a member of the immediate family within the State of New Jersey and up to five (5) consecutive working days leave with pay one of which shall be either the day of death or the day of the funeral, whichever the employee chooses if outside the State. (The funeral service must be held outside the State of New Jersey in order to qualify for the five (5) day leave herein provided.) Proper notification shall be given to the Borough Administrator or designated representative as soon as possible after the death. Proof of death may be required at the sole discretion of the Borough.

B. Immediate family shall include spouse, children, parents, brothers, sisters, grandparents and grandchildren of employee or spouse.

C. An employee must actually attend the funeral in order to be entitled to a leave under this provision. Proof of attendance at the funeral may be required at the sole

discretion of the Borough.

D. In the case of unusual circumstances not specifically covered in this Article, funeral leave may be granted or extended at the discretion of the Borough Administrator. An extension of funeral leave beyond the number of days permitted under Section Aabove shall be charged to an employee's vacation or personal leave at the option of the employee.

ARTICLE XXIII

JURY LEAVE

A. All employees covered under this Agreement shall be excused from his/her employment on all days he/she is required to be present in court in response to a summons for jury service.

B. Any employee so excused shall receive his/her usual compensation for each day he/she is on jury service less the amount of per diem fee he/she receives as shown on a statement issued to the juror by the Sheriff or other court officer making payment of juror fees.

ARTICLE XXIV

MILITARY LEAVE

A. Military Duty Leave:

1. Any full time employee covered by this Agreement may, per relevant, applicable law, be entitled to a leave of absence without pay if the employee is required to serve actively in any component of the Armed Forces of the United States or the State of New Jersey.

2. Military duty leave may extend to three (3) months after the employee's release from required military service. This three (3) month period shall only apply in the event the employee remained on continuous active duty for two (2) years.

3. Sufficient proof of active military duty must be presented to the Borough

Administrator prior to requesting such leave.

B. Military Training Leave:

1. Except as limited herein, a permanent employee working 20 hours or more per week covered by this Agreement who is a member of any component of the Armed Forces of the United States or the State of New Jersey, is hereby entitled to all rights afforded under Federal Law as contained in the Uniformed Services Employment and Reemployment Rights Act (USERRA), Title 38, Chapter 43, of the United States Code.

2. In addition to the foregoing and in accordance with State Law as contained in N.J.S.A 38 and 38A, and N.J.A.C. 4A which provides the following:

Public Employers' Responsibilities:

(a) Employees must be excused for any period of military service including drills, annual training, and other active duty

(b) Provide military leave to public employee members of the National Guard or Reserves. Members of the NJ National Guard are entitled to paid military leave for up to 90 workdays each year.

(c) Members of the reserves are entitled to paid military leave for up to 30 workdays each year. Employees must be permanent, at-will, or Full-Time Temporary.

3. The employee must provide a certified copy of orders for military training to the Borough Administrator prior to requesting leave for such training.

4. Any military pay received by the employee while on military training leave may be retained by the employee and shall be in addition to the regular salary which would have been received from the Borough had such training not been ordered. Except for employees in Section 5 below, when military training leave is granted, it shall be in addition to any vacation leave, sick leave or compensatory time off to which an employee may be entitled.

5. A full time employee who has been continuously employed by the Borough for at

least one (l) full year, at the time such military training is to commence, shall be granted a leave of absence with pay as provided in Section l above.

6. A full time employee who has not been continuously employed by the Borough for at least one (l) full year at the time military training is to commence may only be granted a leave of absence without pay, unless said employee chooses to utilize any accrued vacation leave or compensatory time off, for the duration, or any part of, the period of military field training.

ARTICLE XXV

MATERNITY LEAVE

A. In addition to any leave granted to an employee in accordance with the Family Medical Leave Act ("FMLA"), a leave of absence without pay may be granted up to three (3) months at the sole discretion of the Borough. In no circumstances shall such an approved leave of absence without pay exceed thirty (30) days.

B. The employee has the option of using accumulated sick leave and/or earned vacation leave while she is on maternity leave. Absences in excess of available FMLA, sick and vacation leave will be treated as leave without pay.

ARTICLE XXVI

INJURED ON DUTY

A. Injury leave as distinguished from sick leave shall mean paid leave given to an employee due to absence from duty caused by an accident, illness or injury which occurred while the employee was performing duties and which is compensable under the Workers Compensation Statutes or any policy or workers compensation insurance applicable to the said employee.

B. The employee shall present evidence that he/she is unable to work in the form of a certificate from a physician chosen by the Borough and forwarded to the Borough Clerk within seventy-two (72) hours of the injury or illness or within such reasonable time as the circumstances may require. The Borough may reasonably require that such certificates be

presented from time to time during the course of the illness or injury.

C.All injured on duty leave shall terminate when the physician appointed by the Borough reports in writing that the employee is fit to perform the regular duties of the position held by that employee.

D. In the event the employee through his own independent physician contends that he is entitled to a period of disability beyond the period established by the Borough's treating physician, then and in that event, the burden shall be upon the employee to establish such additional period of disability by obtaining a judgment in the Division of Workers Compensation establishing such further period of disability and such finding by the Division of Workers Compensation or by the final decision of the last reviewing court which shall be binding upon the parties.

E. In the event a dispute arises as to whether an absence shall be computed or designated as sick leave or as an injury on duty, the parties agree to be bound to the decision of an appropriate workers compensation judgment or if there is an appeal there from, the final decision of the last reviewing court.

F. After all injury leave is used as set forth in Section G below, the employee may be granted additional injury leave only upon unilateral approval of the Borough. After all injury leave is used, the employee may elect to use any sick leave, vacation or compensatory time due at the time of the injury and shall then be governed by other appropriate provisions of this contract.

G. Use of Injury Leave - Employees absent from duty due to an accident, illness or injury compensable under the Workers Compensation Statutes or any policy or workers compensation insurance applicable to the said employees and who have completed three (3) months service with the Borough shall be entitled to full pay for a period not in excess of ninety (90) working days for each new and separate injury. In the event an employee is granted an injured on duty leave, the Borough's sole obligation shall be to pay the employee the difference between his or her regular pay and any compensation, disability or other payments received from other sources provided by the Borough. At the Borough's option,

the employee shall surrender and deliver his or her entire compensation payments, in which case the Borough shall issue a check for the employee's full base salary; or the Borough shall pay the employee the difference between his or her full base salary and the amount of other compensation received by said employee.

H. Subject to it being permitted to do so by applicable Federal and State law or regulation, the Borough shall record that portion of the salary checks equal to the amount of the compensation checks covering partial disability (also known as injury leave) and shall notify the employees in writing at the conclusion of each year of the amounts of such partial disability income.

I. Contested Injuries:

1. Charges may be made against sick leave accrual, if any, in any case where the Borough is contesting the employee's eligibility for injury leave.

2. In the event that the Workers Compensation Division determines in favor of the employee, sick leave surcharged shall be re-credited to the employee's sick leave accrual balance.

3. In the event eligibility for payment is denied by the Workers Compensation Division, the employee shall be eligible to utilize sick leave accruals, if any, retroactive to the date of injury, and to use vacation leave thereafter.

4. It is understood that it is the responsibility of the employee to file the appropriate petition in a timely fashion under this paragraph.

J.Medical Proofs - In order to limit the obligation of the Borough for each work connected injury, the Borough may require the employee to furnish medical proof or submit to medical examination by the Borough at its expense to determine whether an injury is compensable under this Section. All records from any such examination shall be the property of the Borough and the employee shall sign all necessary releases, including a HIPAA release, to allow the Borough to obtain such records. Failure of an employee to comply with this provision shall be cause for disciplinary action.

ARTICLE XXVII

EDUCATION INCENTIVE

A. Effective January 1, 1989, each employee covered by this Agreement who has obtained or obtains a Bachelor's degree (B.A. or B.S.) from an accredited college or university in a field of study related to the job title and duties performed by the employee shall upon proper notification and proof to the Borough receive an increment, in addition to all other wages and benefits provided in this Agreement, in the amount of Fifteen Hundred ($1, 500.00) Dollars per year.

B. Effective January 1, 1993, each employee covered by this Agreement who has obtained or obtains an Associate Degree (A.A.) from an accredited college or university in a field of study related to the job title and duties performed by the employee shall upon proper notification and proof to the Borough receive an increment, in addition to all other wages and benefits provided in this Agreement, in the amount of One Thousand ($1,000.00) Dollars per year.

C. Increments paid under this Article shall be prorated from the date of receipt of said degree and shall be paid as part of the employee's bi-weekly salary.

D. An employee shall be entitled to only one (1) increment pursuant to this Article.

E. Anyone hired as an employee of the Borough of Rutherford after the effective date of this contract is not eligible for the benefits contained in this article.

ARTICLE XXVIII

FULLY BARGAINED PROVISIONS

This Agreement represents and incorporates the complete and final understanding and settlement by the parties on all bargainable issues which were or could have been the subject of negotiations. During the term of this Agreement neither party will be required to negotiate with respect to any such matter, whether or not covered by this Agreement, and whether or not within the knowledge or contemplation of either or both of the parties at the time they negotiated or signed this Agreement.

ARTICLE XXIX

SAVINGS CLAUSE

A. It is understood and agreed that if any portion of this Agreement or the application of this Agreement to any person or circumstance shall be invalid, the remainder of this Agreement or the application of such provision to other persons or circumstances shall not be affected thereby.

B. If any such provisions are so invalid, the Borough and the Unit will meet for the purpose of negotiating changes made necessary by applicable law.

ARTICLE XXX

TERMINATION AND EXTENSION OF AGREEMENT

A. The term of this Agreement shall be from January 1, 2011 through December 31, 2016 and its terms and conditions effective with its commencement.

B. All of the provisions of this Agreement shall continue in full force and effect beyond the stated expiration date set forth herein until a successor Agreement is executed and becomes effective.

C. **IN WITNESS WHEREOF,** the parties hereto have entered their hands and seals this 20 day of March 2015.

ATTEST:

Margaret Scanlon, Borough Clerk
(Margaret Scanlon)

BOROUGH OF RUTHERFORD
BERGENCOUNTY, NEW JERSEY

Joseph DeSalvo Jr. Mayor

Richard Sheola, Borough Administrator

WITNESS:

RUTHERFORD DEPT HEADS UNIT

Paul T. Dansbach

Caryn Miller

Christopher Seidler

APPENDIX "A"

The job titles covered by this Agreement are as follows:

DEPARTMENT HEAD TITLES

Director of Recreation/Recreation Superintendant

Construction Official

Social Services Director

Tax Collector

Municipal Court Administrator

Borough Clerk

Public Works Superintendent

Tax Assessor

Fire Marshall

Purchasing Agent

APPENDIX "B"

The annual salaries and salary ranges for job titles ranges for job titles covered by this Agreement are as follows:

DEPARTMENT HEAD 4 STEP PROJECTED SALARY TABLE

Year		% Increase	BASE RATE	STEP 1	STEP 2	MAXIMUM RATE
			Borough Clerk Public Works Superintendent			
2011	@	2.00%	$ 66,766	$ 76,200	$ 85,655	$ 95,088
2012	@	2.00%	68,101	77,724	87,368	96,990
2013	@	2.00%	69,463	79,278	89,115	98,930
2014	@	2.00%	70,852	80,864	90,897	100,909
2015	@	2.00%	72,269	82,481	92,715	102,927
2016	@	2.00%	73,714	84,131	94,569	104,986
2017	@	2.00%	75,188	85,814	96,460	107,086
			Construction Official Fire Marshal Recreation Superintendent			
2011	@	2.00%	$ 65,797	$ 75,176	$ 84,562	$ 93,939
2012	@	2.00%	67,113	76,680	86,253	95,818
2013	@	2.00%	68,455	78,214	87,978	97,734
2014	@	2.00%	69,824	79,778	89,738	99,689
2015	@	2.00%	71,220	81,374	91,533	101,683
2016	@	2.00%	72,644	83,001	93,364	103,717
2017	@	2.00%	74,097	84,661	95,231	105,791
			Purchasing Agent Tax Collector Court Administrator Social Services Director			
2011	@	2.00%	$ 62,815	$ 72,327	$ 81,743	$ 91,074
2012	@	2.00%	64,071	73,774	83,378	92,895
2013	@	2.00%	65,352	75,249	85,046	94,753
2014	@	2.00%	66,659	76,754	86,747	96,648
2015	@	2.00%	67,992	78,289	88,482	98,581
2016	@	2.00%	69,352	79,855	90,252	100,553
2017	@	2.00%	70,739	81,452	92,057	102,564

DEPARTMENT HEAD 5 STEP PROJECTED SALARY TABLE

Year		% Increase	BASE RATE	STEP 1	STEP 2	STEP 3	MAXIMUM RATE
			Borough Clerk Public Works Superintendent				
2011	@	2.00%	$66,766	$73,847	$80,928	$88,009	$ 95,088
2012	@	2.00%	68,101	75,323	82,545	89,767	96,990
2013	@	2.00%	69,463	76,830	84,197	91,564	98,930
2014	@	2.00%	70,852	78,366	85,880	93,394	100,909
2015	@	2.00%	72,269	79,934	87,599	95,264	102,927
2016	@	2.00%	73,714	81,532	89,350	97,168	104,986
2017	@	2.00%	75,188	83,163	91,138	99,113	107,086
			Construction Official Fire Marshal Recreation Superintendent				
2011	@	2.00%	$65,797	$72,833	$79,869	$86,905	$ 93,939
2012	@	2.00%	67,113	74,289	81,465	88,641	95,818
2013	@	2.00%	68,455	75,775	83,095	90,415	97,734
2014	@	2.00%	69,824	77,290	84,756	92,222	99,689
2015	@	2.00%	71,220	78,836	86,452	94,068	101,683
2016	@	2.00%	72,644	80,412	88,180	95,948	103,717
2017	@	2.00%	74,097	82,021	89,945	97,869	105,791
			Purchasing Agent Tax Collector Court Administrator Social Services Director				
2011	@	2.00%	$62,815	$69,880	$76,945	$84,010	$ 91,074
2012	@	2.00%	64,071	71,277	78,483	85,689	92,895
2013	@	2.00%	65,352	72,702	80,052	87,402	94,753
2014	@	2.00%	66,659	74,156	81,653	89,150	96,648
2015	@	2.00%	67,992	75,639	83,286	90,933	98,581
2016	@	2.00%	69,352	77,152	84,952	92,752	100,553
2017	@	2.00%	70,739	78,695	86,651	94,607	102,564

DEPARTMENT HEAD 7 STEP PROJECTED SALARY TABLE

Year		% Increase	BASE RATE	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	MAXIMUM RATE
			Borough Clerk Public Works Superintendent						
2011	@	2.00%	$ 66,766	$ 71,486	$ 76,206	$ 80,926	$ 85,646	$ 90,366	$ 95,088
2012	@	2.00%	68,101	72,916	77,731	82,546	87,361	92,176	96,990
2013	@	2.00%	69,463	74,374	79,285	84,196	89,107	94,018	98,930
2014	@	2.00%	70,852	75,862	80,872	85,882	90,892	95,902	100,909
2015	@	2.00%	72,269	77,379	82,489	87,599	92,709	97,819	102,927
2016	@	2.00%	73,714	78,926	84,138	89,350	94,562	99,774	104,986
2017	@	2.00%	75,188	80,504	85,820	91,136	96,452	101,768	107,086
			Construction Official Fire Marshal Recreation Superintendent						
2011	@	2.00%	$ 65,797	$ 70,487	$ 75,177	$ 79,867	$ 84,557	$ 89,247	$ 93,939
2012	@	2.00%	67,113	71,897	76,681	81,465	86,249	91,033	95,818
2013	@	2.00%	68,455	73,335	78,215	83,095	87,975	92,855	97,734
2014	@	2.00%	69,824	74,802	79,780	84,758	89,736	94,714	99,689
2015	@	2.00%	71,220	76,297	81,374	86,451	91,528	96,605	101,683
2016	@	2.00%	72,644	77,823	83,002	88,181	93,360	98,539	103,717
2017	@	2.00%	74,097	79,379	84,661	89,943	95,225	100,507	105,791
			Purchasing Agent Tax Collector Court Administrator Social Services Director						
2011	@	2.00%	$ 62,815	$ 67,525	$ 72,235	$ 76,945	$ 81,655	$ 86,365	$ 91,074
2012	@	2.00%	64,071	68,875	73,679	78,483	83,287	88,091	92,895
2013	@	2.00%	65,352	70,252	75,152	80,052	84,952	89,852	94,753
2014	@	2.00%	66,659	71,657	76,655	81,653	86,651	91,649	96,648
2015	@	2.00%	67,992	73,090	78,188	83,286	88,384	93,482	98,581
2016	@	2.00%	69,352	74,552	79,752	84,952	90,152	95,352	100,553
2017	@	2.00%	70,739	76,043	81,347	86,651	91,955	97,259	102,564

APPENDIX "C"

Medical Plan to be attached

aetna

Aetna Choice® POS – Rutherford Open Access $15

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

Coverage Period: 01/01/2014 - 12/31/2014
Coverage for: Individual + Family | **Plan Type:** POS
BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual $0 / Family $0. Out-of-network: Individual $250 / Family $500.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: Individual $400 / Family $800. Out-of-network: Individual $2,000 / Family $4,000.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, in-network hospital copays, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	30% coinsurance	None
	Specialist visit	$25 copay per visit	30% coinsurance	None
	Other practitioner office visit	$25 copay per visit	30% coinsurance	Unlimited visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	30% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Pre-authorization may be required for out-of-network care.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered.
	Non-preferred brand drugs	Not covered	Not covered	Not covered.
	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	——— None ———
	Physician/surgeon fees	No charge	30% coinsurance	——— None ———
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	$50 copay per visit	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day	30% coinsurance	$2,500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Physician/surgeon fee	No charge	30% coinsurance	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	30% coinsurance	——— None ———
	Mental/Behavioral health inpatient services	$500 copay per day	30% coinsurance	$2,500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	$25 copay per visit	30% coinsurance	——— None ———

[redacted]	Substance use disorder inpatient services	$500 copay per day	30% coinsurance	$2,500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	None
	Delivery and all inpatient services	$500 copay per day	30% coinsurance	$2,500 maximum copay per individual per stay. Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Pre-authorization may be required for out-of-network care.
	Rehabilitation services	No charge	30% coinsurance	None
	Habilitation services	No charge	30% coinsurance	Coverage is limited to children up to age 21 for Autism.
	Skilled nursing care	$500 copay per day	30% coinsurance	$2,500 maximum copay per individual per stay. Coverage is limited to 100 days in-network and 60 days out-of-network per calendar year. Pre-authorization may be required for out-of-network care.
	Durable medical equipment	No charge	30% coinsurance	None
	Hospice service	No charge	30% coinsurance	Pre-authorization may be required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to 1 hearing aid per ear to a maximum of $1,000 every 24 months
- Infertility treatment – Benefit limitations may apply.
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

- Additionally, a consumer assistance program can help you file an **appeal**. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Provide Minimum Value Standard?

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

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

Para obtener asistencia en Español, llame al 1-888-982-3862.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,370
- **Patient pays:** $170

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$170
Total	$170

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,320
- **Patient pays:** $3,080

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$2,930
Total	$3,080

Note: Your plan may have both copays and **coinsurance** for covered services; if so, these examples use copays only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Aetna Choice® POS II – Borough of Rutherford- $20/$30 PPO BUY UP

Coverage Period: 02/01/1[illegible]4 - 12/31/20
Coverage for: Individual + Family | Plan Type: PC
BERGEN MUNICIPAL EMPLOYEE BENEFITS FUN

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual $500 / Family $1,000. Out-of-network: Individual $1,250 / Family $2,500. Does not apply to office visits, preventive care, and emergency care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual $1,000 / Family $2,000. Out-of-network: Individual $2,500 / Family $5,000.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	30% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$30 copay per visit	30% coinsurance	——— None ———
	Other practitioner office visit	$30 copay per visit	30% coinsurance	Coverage is limited to 30 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	30% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay per visit	30% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	$30 copay per visit	30% coinsurance	——— None ———

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered.
	Non-preferred brand drugs	Not covered	Not covered	Not covered.
	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	——— None ———
	Physician/surgeon fees	10% coinsurance	30% coinsurance	——— None ———
If you need immediate medical attention	Emergency room services	$100 copay per visit then 20% coinsurance	$100 copay per visit then 20% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	30% coinsurance	No coverage for non-emergency transport.
	Urgent care	$30 copay per visit	$30 copay per visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day	30% coinsurance	$500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Physician/surgeon fee	No charge	30% coinsurance	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit	30% coinsurance	——— None ———
	Mental/Behavioral health inpatient services	$100 copay per day	30% coinsurance	$500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	$30 copay per visit	30% coinsurance	——— None ———

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	$100 copay per day	30% coinsurance	$500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	Prenatal- $30 Copay for 1st visit then No charge Postnatal- No Charge	30% coinsurance	None
	Delivery and all inpatient services	$100 copay per day	30% coinsurance	$500 maximum copay per individual per stay. Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	$30 copay per visit	30% coinsurance	Coverage is limited to 30 visits per condition per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	$30 copay per visit	30% coinsurance	Coverage is limited to children up to age 21 for Autism.
	Skilled nursing care	$100 copay per day	30% coinsurance	$500 maximum copay per individual per stay. Coverage is limited to 120 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-authorization required for out-of-network care.
	Hospice service	Inpatient: $100 copay per day. Outpatient: 10% coinsurance.	30% coinsurance	$500 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam every 24 months.

If your child needs dental or eye care	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care - Coverage is limited to 30 visits per calendar year.
- Infertility treatment - Benefit limitations may apply.
- Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year.
- Routine eye care - Coverage is limited to 1 routine eye exam every 24 months.

Your Rights to Continue Coverage:

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

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

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

Does this Coverage Provide Minimum Value Standard?

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

Language Access Services:

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

About these Coverage Examples:

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

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,580
- **Patient pays:** $960

Sample care costs:

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

Patient pays:

Deductibles	$500
Copays	$290
Coinsurance	$0
Limits or exclusions	$170
Total	$960

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,660
- **Patient pays:** $3,740

Sample care costs:

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

Patient pays:

Deductibles	$500
Copays	$210
Coinsurance	$100
Limits or exclusions	$2,930
Total	$3,740

Note: Your plan may have both copays and coinsurance for covered services; if so, these examples use copays only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Aetna Choice® POS II – Borough of Rutherford $25/$40 PPO CORE

Coverage Period: 02/0 014 - 12/31/2
Coverage for: Individual + Family | Plan Type: P
BERGEN MUNICIPAL EMPLOYEE BENEFITS FU

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual **$1,000** / Family **$2,000.** Out-of-network: Individual **$2,500** / Family **$5,000.** Does not apply to office visits, preventive care, and emergency care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual **$2,000** / Family **$4,000.** Out-of-network: Individual **$5,000** / Family **$10,000.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$40 copay per visit	40% coinsurance	——— None ———
	Other practitioner office visit	$40 copay per visit	40% coinsurance	Coverage is limited to 30 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	40% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay per visit	40% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	$40 copay per visit	40% coinsurance	——— None ———

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered.
	Non-preferred brand drugs	Not covered	Not covered	Not covered.
	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room services	20% coinsurance after $100 copay per visit	20% coinsurance after $100 copay per visit	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	40% coinsurance	No coverage for non-emergency transport.
	Urgent care	$40 copay per visit	$40 copay per visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per day	40% coinsurance	$1,000 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Physician/surgeon fee	No charge	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	40% coinsurance	None
	Mental/Behavioral health inpatient services	$200 copay per day	40% coinsurance	$1,000 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	$40 copay per visit	40% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	$200 copay per day	40% coinsurance	$1,000 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	Prenatal- $40 Copay for 1st visit, then No Charge Postnatal- No Charge	40% coinsurance	None
	Delivery and all inpatient services	$200 copay per day	40% coinsurance	$1,000 maximum copay per individual per stay. Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	$40 copay per visit	40% coinsurance	Coverage is limited to 60 visits per condition per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	$40 copay per visit	40% coinsurance	Coverage is limited to children up to age 21 for Autism.
	Skilled nursing care	$200 copay per day	40% coinsurance	$1,000 maximum copay per individual per stay. Coverage is limited to 120 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Hospice service	Inpatient: $200 copay per day. Outpatient: 20% coinsurance.	40% coinsurance	$1,000 maximum copay per individual per stay. Pre-authorization required for out-of-network care.
	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam every 24 months.

If your child needs dental or eye care	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care - Coverage is limited to 30 visits per calendar year.
- Infertility treatment - Benefit limitations may apply.
- Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year.
- Routine eye care - Coverage is limited to 1 routine eye exam every 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

- Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

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

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

Does this Coverage Provide Minimum Value Standard?

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

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

Para obtener asistencia en Español, llame al 1-888-982-3862.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,970
- **Patient pays:** $1,570

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$400
Coinsurance	$0
Limits or exclusions	$170
Total	$1,570

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,110
- **Patient pays:** $4,290

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$170
Coinsurance	$190
Limits or exclusions	$2,930
Total	$4,290

Note: Your plan may have both copays and coinsurance for covered services; if so, these examples use copays only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Aetna HealthFund® Aetna Choice® POS II - HDHP Plan – Borough of Rutherford

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual **$1,250** / Family **$2,500.** Out-of-network: Individual **$1,250** / Family **$2,500.** Does not apply to preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual **$6,250** / Family **$12,500.** Out-of-network: Individual **$6,250** / Family **$12,500.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

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

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	20% coinsurance	50% coinsurance	——— None ———
	Other practitioner office visit	20% coinsurance	50% coinsurance	——— None ———
	Preventive care /screening /immunization	No charge	50% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	——— None ———

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. * Prescription Drugs are covered through Express Scripts and are excluded from the Aetna plan. More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	20% Retail/Mail Order Copay	Not covered	34 Days or 100 Units Retail 90 Days Mail Order
	Preferred brand drugs	20% Retail/Mail Order Copay	Not covered	34 Days or 100 Units Retail 90 Days Mail Order
	Non-preferred brand drugs	20% Retail/Mail Order Copay	Not covered	34 Days or 100 Units Retail 90 Days Mail Order
	Specialty drugs	20% Curascripts Mail Order Copay	Not covered	30 Days Curascripts Mail Order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——— None ———
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——— None ———
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	50% coinsurance	No coverage for non-emergency transport.
	Urgent care	20% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——— None ———
	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	——— None ———

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

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	——— None ———
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	——— None ———

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 30 visits per condition per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	20% coinsurance	50% coinsurance	Coverage is limited to children up to age 21 for Autism.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 120 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Hospice service	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam every 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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- Acupuncture
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- Glasses (Adult)
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- Weight loss programs

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- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,340
- **Patient pays:** $2,200

Sample care costs:

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

Patient pays:

Deductibles	$1,250
Copays	$0
Coinsurance	$780
Limits or exclusions	$170
Total	$2,200

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $990
- **Patient pays:** $4,410

Sample care costs:

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

Patient pays:

Deductibles	$1,250
Copays	$0
Coinsurance	$230
Limits or exclusions	$2,930
Total	$4,410

Note: Your plan may have both copays and coinsurance for covered services; if so, these examples use copays only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

APPENDIX "D"

Prescription plan to be attached

EXCLUSIONS

Eligible Expense will not include, and no payment will be made under this policy for:

1. Charges incurred because of injury or sickness covered by any applicable worker's compensation law.
2. Charges for medication furnished to an individual who is confined as an in-patient in a hospital, rest home, sanitarium, nursing home or similar institution.
3. Charges for any refill of a Prescription in excess of the number specified by the physician, or for any refill dispensed after one year from the date of the physician's original order.
4. Charges for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, provided the required coverage is contrary to a religious employer's bona fide religious tenets and such employer requested an exclusion.
5. Anti-wrinkle agents (e.g. Renova), regardless of intended use.
6. Antivirals, specifically indicated for the treatment of HIV/AIDS (prior authorization required).
7. Dermatologicals, hair growth stimulants or cosmetic hair removal products (e.g. Vaniqa).
8. Growth Hormones (prior authorization required).
9. Immunization agents, blood or blood plasma.
10. Non-legend drugs other than insulin those listed above.
11. Tretinoin topical (e.g. Retin-A), for individuals 26 years of age or older.
12. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above.
13. Drugs labeled "Caution–limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.

THIS BROCHURE IS INTENDED AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control terms and conditions.

25758934

Bollinger®
Insurance Solutions

PRESCRIPTION DRUG BENEFIT SUMMARY

PREPARED FOR:

BOROUGH OF RUTHERFORD

GROUP #: PD0895

UNDERWRITTEN BY:
MONUMENTAL LIFE INSURANCE COMPANY
CEDAR RAPIDS, IOWA
A TRANSAMERICA COMPANY

PD10000GPM.NJ
8-16-2012

CVS CAREMARK

Getting Started

The following is intended to be a general description of your prescription drug benefit program. The Master Policy shall dictate all terms, limitations and other conditions pertaining to this plan. Additional information and useful links regarding your plan can be found at www.BollingerDrugCard.com.

Your Co-Payments

Non-Preferred Brand Drugs	$40.00
Preferred Brand Drugs	$25.00
Generic Drugs	$10.00
Mail Order (90 day supply)	Same as retail co-pay

Dependent Eligibility

Children are covered until their 26th birthday through the end of the calendar year. Dependent children may be eligible for coverage up to age 31 under the New Jersey Dependent Under Age 31 election. Please refer to http://www.state.nj.us/dobi/division_consumers/du31.html for eligibility requirements and additional information.

Pharmacy Network

CVS Caremark serves as your national pharmacy benefit network. Its national network of over 65,000 participating pharmacies ensures that there is a location near your home or work. Go to www.Caremark.com for more information or to locate a pharmacy near you.

Retail Dispensing Limit

You may receive up to a 34 day supply or 100 unit doses, whichever is greater. for one co-payment at the retail pharmacy.

Specialty Pharmacy

CVS Caremark's network of fourteen specialty pharmacies nationwide serves patients who require complex drug therapies to treat a number of conditions such as cancer or multiple sclerosis. These medications are typically delivered to you through the mail and your retail co-payment applies. Learn more by visiting www.CVSCaremarkSpecialtyRx.com

Mail Order Service

If you take maintenance medication on a regular basis you may wish to fill your prescriptions through Caremark's mail order pharmacy. You may obtain up to a 90 day supply of your medication for one co-payment and you will save both time and money because the medications are delivered right to your door. Signing up i simple at www.Caremark.com. You may also use the FastStart program to get thin started. Sign in and register at www.Caremark.com or call toll free 800-875-0867 Monday through Friday 8 AM - 8 PM EST. Have your plan information, doctor's name and phone number, and list of medications available when you call.

ID Card

You will initially receive either one or two ID cards depending upon your tier of coverage You may request additional cards at no extra cost. Contact Customer Service at 800-526-1379 x-8019. Be certain your pharmacist updates your record with the information from your card.

Ask for Generics

Each time you fill a prescription you can save money by asking for a generic medication. Ask your doctor to consider prescribing a generic or permitting the st stitution of a generic for a brand whenever possible.

Covered Drugs

- Legend Drugs
- Insulin
- Disposable insulin needles/syringe
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes Tape).
- Blood Glucose Monitors.
- Infertility Medication.
- Lancets.
- Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.
- Compound Medication of which at least one ingredient is a legend drug.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.
- Legend Female Contraceptives.

APPENDIX "E"

Dental Plan to be attached

Delta Plan
In-Network/DMO Plan
Group # 3604-9343

Flagship Dental Plans
1-800-722-3524 New Jersey
1-800-848-3524 Out of State

Plan NJ5

PRIMARY SERVICES

PRIMARY SERVICES are covered if necessary and performed by your attending Plan Dentist subject to the Limitations, Exclusions and Governing Administrative Policies of the Program.

PROCEDURE CODES		ENROLLEE PAYS
DIAGNOSTIC		
D0120	Periodic oral evaluation est. patient	No Cost
D0140	Limited oral evaluation	No Cost
D0145	Oral evaluation for a pat. Under 3yrs of	No Cost
D0150	Comprehensive oral evaluation	No Cost
D0160	Detailed and extensive oral exam	No Cost
D0170	Re-eval., limited (est. patient)	No Cost
D0180	Comprehensive periodontal evaluation	No Cost
D0210	Intraoral radiographs	No Cost
D0220/0230	Intraoral periapical film-each add. film	No Cost
D0240	Intraoral occlusal film	No Cost
D0260	Extraoral -each additional film	No Cost
D0270/0272	Bitewing single/two films	No Cost
D0273/0274	Bitewings-three/four films	No Cost
D0290	Post./Ant. or lateral skull/facial film	No Cost
D0330	Panoramic film	No Cost
D0415	Bacteriologic studies	No Cost
D0460/0470	Pulp Vitality Tests/Diagnostic casts	No Cost
	Initial exam by Specialist	$ 25.00
PREVENTIVE		
D1110/1120	Prophylaxis-adult/child –two treatments per any 12 month period	No Cost
D1203	Top. fluoride incl./excl. prophy child	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant – per tooth	$ 20.00
D1510/1515	Space maintainer-fixed uni./bilateral	No Cost
D1520/1525	Space maintainer-remov. uni./bialateral	No Cost
D1550/1555	Recementation/Removal of space maint.	No Cost

RESTORATIVE (FILLINGS)
Includes indirect pulp capping, bases, liners and acid Etch procedures

Silver (Amalgam) Restorations- Primary/Permanent Teeth:

D2140	Amalgam-one surface prim./perm.	No Cost
D2150	Amalgam-two surfaces prim./perm.	No Cost
D2160	Amalgam-three surfaces prim./perm.	No Cost
D2161	Amalgam-four or more prim./perm.	No Cost

Resin (White) Restoration, Anterior/Posterior Teeth:

D2330	Resin, one surface, anterior	No Cost
D2331	Resin, two surfaces, anterior	No Cost
D2332	Resin, three surfaces, anterior	No Cost
D2335	Resin, involving incisal angle anterior	No Cost
D2390	Resin based composite crown, anterior	$ 75.00
D2391	Resin based composite one surf. post.	$ 20.00
D2392	Resin based composite two surf. post.	$ 25.00
D2393	Resin based composite three surf. post.	$ 35.00
D2394	Resin based composite four + surf. post	$ 50.00
D2542/43/44	Onlay-metallic-two/three/four + surf.	$190.00

Crowns:
Limitations may apply, refer to your Benefit Plan Summary booklet.

D2710/12	Resin / ¾ Resin (indirect)	$75.00/$190.00
D2720	Resin with high noble metal*	$200.00
D2721	Resin with predominately base metal	$200.00
D2722	Resin with noble metal*	$200.00
D2740	Porcelain/ceramic substrate*	$200.00
D2750	Porcelain fused to high noble metal*	$200.00
D2751	Porcelain fused to predom. base metal	$200.00
D2752	Porcelain fused to noble metal*	$200.00
D2780/81/82	¾ cast high noble/base./noble metal*	$190.00
D2783	¾ porcelain / ceramic	$190.00
D2790	Full cast high noble metal*	$200.00
D2791	Full cast predominately base metal	$200.00
D2792	Full cast noble metal*	$200.00
D2910/15/20	Recement inlay / post & core/ crown	No Cost
D2930/31	Prefab. stainless steel (prim/perm)	$ 50.00
D2932	Prefabricated resin	$ 75.00
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention-per tooth, + restoration	$ 25.00
D2952/53	Cast post and core + crown/+ add. post	$175.00
D2954	Prefabricated post and core + crown	$225.00
D2957	Each additional prefabricated post	$175.00

ENDODONTICS

D3110/3120	Pulp capping (direct/indirect)	No Cost
D3220/3221	Therapeutic pulpotomy/Pulpal debrib.	No Cost
D3230/40	Pulpal therapy (anterior/posterior)	No Cost
D3310	Anterior root canal	No Cost
D3320	Bicuspid root canal	No Cost
D3330	Molar root canal	No Cost
D3346	Retreatment previous root canal (ant.)	No Cost
D3347	Retreatment previous root canal (post.)	No Cost
D3348	Retreatment previous root canal (molar)	No Cost
D3410	Apicoectomy-anterior	No Cost
D3421/25/26	Apico.-bicuspid/molar/ and each add. rt.	No Cost
D3430	Retrograde filling – per root	No Cost
D3450	Root Amputation – per root	No Cost
D3920	Hemisection (include root removal)	No Cost

SPECIALTY SERVICES--Are covered if necessary by a Plan Dental Specialist with a referral from your primary care dentist. Services are subject to the Limitations, Exclusions and Governing Administrative Policies of the Program

PERIODONTICS

D4210	Gingivectomy or Gingivoplasty, Qd.	No Cost
D4211	Gingivectomy or gingivoplasty, per tooth (if fewer than four teeth)	No Cost
D4230/4231	Anatomical crown exp.4+/1-3 per qd.	No Cost
D4240	Gingival flap procedures Qd.	No Cost
D4241	Gingival flap proc. including root plan.	No Cost
D4249	Clinical crown length.-hard tissue	No Cost

D4261	Osseous surgery 1 to 3 teeth per Qd.	No Cost
D4263	Bone replacement graft (first site in Qd.	No Cost
D4264	Bone replacement graft (each add. site)	No Cost
D4270	Pedicle soft tissue graft procedure	No Cost
D4271/73	Free soft tissue graft(include donor site)	No Cost
D4341	Periodontal root planing 4 more Qd.	No Cost
D4342	Periodontal root planing, 1-3 teeth Qd.	No Cost
D4355	Full mouth debridement to enable com.	No Cost
D4910	Periodontal maintenance	No Cost

PROSTHETICS (Removable and Fixed bridges & dentures)

D5110	Complete upper denture	$200.00
D5120	Complete lower denture	$200.00
D5211/12	Partial resin denture, upper/lower	$210.00
D5213	Partial denture, upper	$220.00
D5214	Partial denture, lower	$220.00
D5281	Removable partial denture	$200.00
D5410/5411	Denture Adjustments-max./mand.	No Cost
D5421/5422	Partial Adjustments-max./mand.	No Cost
D5510	Repair broken complete denture	$ 50.00
D5520	Replace missing/broken teeth(per tooth)	$ 50.00
D5610/5620	Repair resin/cast framework part. dent.	$ 50.00
D5630	Repair / replace broken clasp	$ 50.00
D5640	Replace broken teeth per tooth	$ 50.00
D5650	Add tooth to existing. partial	$ 60.00
D5660	Add clasp to existing partial	$ 60.00
D5670/71	Replace all teeth&acrylic (max./mand.)	$150.00
D5730/5731	Reline full dent. max./mand. (chairside)	$ 50.00
D5740/41	Reline max/mand. part. dent.(chairside)	$ 50.00
D5750/5751	Reline full max./mand. denture (lab.)	$ 70.00
D5760/61	Reline max./mand. partial dent. (lab.)	$ 70.00
D6210	Pontic cast high noble metal*	$200.00
D6211	Pontic cast predominantly base metal	$200.00
D6212	Pontic cast noble metal*	$200.00
D6240	Pontic porcelain fused to high noble*	$200.00
D6241	Pontic porcelain fused to base metal	$200.00
D6242	Pontic porcelain fused to noble metal*	$200.00
D6245	Pontic porcelain / ceramic	$200.00
D6250	Pontic resin w/high noble metal*	$200.00
D6251	Pontic resin w/predom. base metal	$200.00
D6252	Pontic resin with noble metal*	$200.00
D6545	Retainer cast metal for resin bond fix	$200.00
D6610	Onlay cast high noble metal, two surf.*	$190.00
D6611	Onlay cast high noble metal, 3+ surf *	$190.00
D6612	Onlay cast predominately base metal 2	$190.00
D6613	Onlay cast pred. base metal 3+ surf.	$190.00
D6614	Onlay cast noble metal, two surfaces	$190.00
D6615	Onlay cast noble metal, three + surf.	$190.00
D6710	Crown indirect resin based composite	$ 75.00
D6720/21/22	Crown resin w/high noble/base/noble*	$200.00
D6740	Crown porcelain / ceramic	$200.00
D6750	Crown porcelain fused to high noble*	$200.00
D6751	Crown porcelain fused to base metal	$200.00
D6752	Crown porcelain fused to noble metal*	$200.00
D6780	Crown ¾ cast high noble metal*	$190.00
D6781	Crown-¾ cast pred. base metal	$190.00
D6782	Crown-¾ cast noble metal*	$190.00
D6790	Crown full cast high noble metal*	$200.00
D6791	Crown full cast predominantly base	$200.00
D6792	Crown full cast noble metal*	$200.00
D6930	Recement bridge	No Cost
D6970	Post and core+ fixed part. denture, ind.	$225.00
D6972	Prefabricated post and core +fixed part.	$225.00
D6973	Core build up for retainer,+ any pins	No Cost
D6976/77	Each add.cast/add. prefab.post same tth	$175.00

*Note: Base metal is the benefit. Noble and High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast post and cores, inlays and onlays. Porcelain on molars is considered optional treatment.

ORAL SURGERY

D7111	Coronal remnants-deciduous teeth	No Cost
D7140	Ext. erupted tooth or exposed root	No Cost
D7210	Surgical removal of erupted tooth req.	No Cost
D7220	Removal of impacted tooth/soft tissue	No Cost
D7230	Removal of impacted tooth/par. bony	No Cost
D7240/41	Removal of impacted tooth/com. bony	No Cost
D7250	Surgical removal of residual roots	No Cost
D7260	Oroantral fistula closure	No Cost
D7280/83	Surg. exp.of unerupt. tth/dev.aid erupt.	No Cost
D7285/86	Biopsy of oral tissue (hard/ soft)	No Cost
D7310/11/20/21	Alveoloplasty in conj.w/wo extraction	No Cost
D7340/50	Vestibuloplasty-sec. Epit/Soft tissue grf	No Cost
D7410	Excision of benign lesion (up 1.25 cm)	No Cost
D7411	Excision of benign lesion (+1.25 cm)	No Cost
D7440/41	Excision of mal. up to 1.25/+1.25 cm	No Cost
D7450	Removal of cyst or tumor (up 1.25 cm)	No Cost
D7451	Removal of cyst or tumor (+1.25 cm)	No Cost
D7460	Removal of cyst/tumor nonodon.(T1.25)	No Cost
D7461	Removal of cyst/tumor nonodon.(+1.25)	No Cost
D7465	Destruction of lesion (s), by report	No Cost
D7471	Removal of lateral exost. (maxi./mand.)	No Cost
D7472/73	Removal of torus palantinus/mandibula	No Cost
D7485	Surgical reduction of mand. oss. Tuber.	No Cost
D7510/11	Incision & drainage of abscess intraoral	No Cost
D7520/21	Incision & drainage of abscess extraoral	No Cost
D7530/40	Removal of foreign/reaction bodies	No Cost
D7550	Removal of non-vital bone (part.ostect)	No Cost
D7960	Frenulectomy, frenectomy or frenotomy	No Cost
D7963	Frenuloplasty	No Cost
D7970	Excision of hyperplastic tissue-per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

ORTHODONTICS

Includes initial exam, diagnosis, consultation, initial banding, 24 months of active comprehensive treatment and retention phase of treatment of up to 24 months. This includes construction, placement and adjustment to retainers and office visits for a maximum of 24 months.

Full orthodontic case depending on group contract.

ADJUNCTIVE SERVICES

D9110	Palliative (emergency) treatment (pain)	No Cost
D9210	Local anesthesia not in conj.w/oper./surg.	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9220	General anesthesia 1st 30min.	No Cost
D9221	General anesthesia each additional 15min.	No Cost
D9241/42	Intravenous sed./analg. 1st 30 min./15min.	No Cost
D9310	Consultation	No Cost
D9430	Office visit observation (regular hours)	No Cost
D9440	Office visit after regular hours	No Cost
D9450	Case presentation, detailed & exten. trea.	No Cost
D0125	Failed appt. without 24 hours	$10.00 per 15 min.

OUT - OF - AREA EMERGENCY CARE

DeltaCare will reimburse the enrollee for actual charges less any applicable copayment, up to $100.00 per enrollee when receiving emergency care while temporarily more than 35 miles from the attending primary care dental office.

Services that are more expensive than the treatment usually provided under accepted dental practice standards are considered optional treatment. The patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional or more expensive treatment plus any applicable copayment.

All services are subject to the limitations and exclusions outlined in your Dental Benefit Plan summary booklet.

Description of Covered Services

ollowing page for program descriptions

If you are in
Delta Dental PPO

entive & Diagnostic Services (No Deductible) 70%

xams, Cleanings, (each twice per calendar year per person, ages 14 and older e considered adults)

-rays-full mouth series or panoramic (either one, once in three years)

-rays-bitewing (twice per calendar year)

-rays-single films (multiple x-rays on the same date of service will not exceed e benefit of a full-mouth series)

luoride Treatment (once per calendar year, for eligible children to age 19, ombinations with cleanings are applied to time limits for both)

pace Maintainers (once per space for missing posterior primary teeth, for ildren under age 14)

onsultations are counted as exams for purposes of frequency limitations

aining Basic & Crowns (No Deductible) 70%

illings - composite and amalgam. Payment is allowed for one restoration per oth surface in 365 days (composite fillings on back teeth are given the alternate enefit of an amalgam filling)

xtractions, Oral Surgery (impacted wisdom teeth claims should first go to edical carrier)

ndodontics (root canals on permanent teeth and root surgery each once per 24 s)

dontics (have specific frequency limitations, pre-treatment estimate is rongly recommended - e.g. surgery once per 36 months)

ealants (1st and 2nd permanent, decay-free molars, once in a lifetime per tooth, or children to age 16)

rowns and crown-related procedures (post and core, core buildup, etc., once very five years, permanent teeth only, for ages 12 and older)

thodontics (No Deductible) 50%

ridgework (once every five years, for ages 16 and older) (bridges with four or ore missing teeth in that arch may be given an alternate benefit of a partial enture)

ull & Partial Dentures (either one, once every five years, partial dentures for ges 16 and older) (fixed bridges and removable partial dentures are not benefits the same arch; benefits will be provided for the removable partial denture nly)

epair of Dentures (Repair of existing prosthetic appliances)

nlays (inlays are only payable when done in conjunction with an onlay; by emselves they are given the alternate benefit of an amalgam filling)

	If you are in DeltaPreferred Option
Calendar Year Maximum (per person)	[redacted]
Calendar Year Deductible	
▪ Individual	[redacted]
▪ Family (family deductible is accumulated by individual deductibles)	[redacted]
Orthodontia (Employees & Dependents)	[redacted]
Orthodontic treatment is a benefit limited to once in a lifetime.	
▪ Maximum (Lifetime)	[redacted]
▪ Deductible (Lifetime)	[redacted]

Description of Programs

Delta Dental PPO - See Explanation under "Product Descriptions" section at back of booklet.

Under all programs, non-participating dentists may balance bill above the maximum allowable charge.