754

OFFICER CONTRACT

P.B.A. Local 197

HARRY C. GROMB, PRESIDENT

JANUARY 1, 1997 THROUGH DECEMBER 31, 2002

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*

* Section Numbers

For The County _____

For The PBA _____

1. WITNESSETH

Whereas the County of Passaic does recognize the Patrolmen's Benevolent Association, Local # 197, as the exclusive representative for the purpose of collective negotiations with respect to wages, hours of work, and other terms and conditions of employment for sheriff's and correctional officers, exclusive in this Agreement, whose duties are supervisory.

Now therefore, be it resolved, that the Employer and the Association mutually agree that the following shall represent the Agreement reached as a result of collective negotiations for the contract years , effective January 1, 1997, and shall remain in full force and effect until December 31, 2002, or until a successor Agreement is negotiated and executed, whichever shall last occur.

All items in this contract shall remain in full force and shall continue to be paid until successor Agreement is negotiated and executed--including increments,clothing maintenance/allowance, etc...

2. PREAMBLE

This Agreement has, for its purpose, the promotion of harmonious relations between the Employer and its employees, the establishment of equitable and peaceful procedure for the resolution of differences, the establishment of rates of pay, hours of work and other conditions of employment satisfactory to both parties, and the avoidance of interruption or interference with the efficient operation of the Employer which is essential to the well being of the citizens of Passaic County.

3. GRIEVANCE PROCEDURE

A grievance shall be any difference of opinion, controversy, or dispute arising between the parties(PBA 197 & the County of Passaic) hereto relating to any matter of wages, hours, disciplinary action, and working conditions, or any dispute between the parties involving interpretation or application of any provision of the Agreement.

The Employer and Association mutually agree to the following grievance steps:

A. The employee shall present the grievance, either verbally or in written form, to the employee's immediate shift commander

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within five (5) days of its occurrence. The shift commander shall then attempt to adjust the matter and shall respond verbally to the employee within five (5) working days.

B. If the grievance has not been settled, it shall be presented in writing by a PBA representative to the appropriate division head within five (5) days after the shift commander's response is received or due. The division head shall then respond in writing to the PBA representative within five (5) working days.

C. If the grievance still remains unsettled, it shall be presented in writing by the PBA representative to the Sheriff within five (5) days after response of the division head is received or due. The Sheriff or his designated representative shall respond verbally or in writing to the PBA representative within ten (10) working days.

D. If the grievance is still unresolved within ten (10) days after written notice is received or due from the Sheriff, either party (PBA 197 or The County of Passaic)may request arbitration of the grievance, pursuant to PERC rules and regulations (19:12-5.1). The cost for arbitration shall be borne equally by the County of Passaic and the PBA.

4. MANAGEMENT RIGHTS

The public Employer retains the rights, in accordance with applicable laws and procedures,to:a)direct employees; b)hire, promote transfer, assign and retain employees in positions within the agency, as well as to suspend, demote, discharge, or take reasonable disciplinary action against employers; c)relieve employees from duties because of lack of work or other legitimate reasons; d) maintain the efficiency of the government operations entrusted to the; e) determine the methods, means and personnel by which such operations are to be conducted; f) take whatever action may be necessary to carry out the mission of the agency in situations of emergency; and g) take disciplinary action when an employee fails to comply with reasonable management requests.

5. Workweek--Hours of Work

A. All employees employed in the continuous operation of the Corrections & Patrol Units shall have a workweek, inclusive of week-ends, consisting of four (4) consecutive days on and two (2) consecutive days off.

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The basic hours of work for 4 & 2 employees shall be from 7:00 AM to 3:00 PM, 3:00 PM to 11:00PM,and 11:00 PM to 7:00 AM. All 4 & 2 employees shall be allowed one (1) thirty - (30) minute lunch period at a time and in an area designated by the supervisor.

The basic hours of work for 5 & 2 employees shall be from 8:00 AM to 4:00 PM. All 5 & 2 employees shall be allowed one (1) thirty - (30) minute lunch period.

B. For those employees assigned to the courthouse, the basic workweek shall consist of Monday through Friday from 8:15 AM to 4:15 PM, inclusive of a one (1) hour lunch period.

C. As a condition of employment, employees must be available to work any and all shifts as needed to maintain the efficient operation of the Passaic County Sheriff's Department. When necessary, employees may be placed on a staggering starts and finishes.

D. If an employee is more than thirty (30) minutes late in reporting without good cause, the Sheriff or his designee may send the employee home for the balance of the working day, in which event s/he shall not receive any pay for that day.

6. Overtime Payment

A. For correctional, courthouse and patrol officers, time and one-half the employee's regular rate of pay shall be paid in fifteen (15) minute segments after such employee has worked ten (10) minutes beyond the normal eight (8) hour work shift or both 4 & 2 and 5 & 2 personnel, provided that such employee reported for work on time for his/her original shift, and further provided that said employee worked the full shift.

B. If an employee is scheduled to work on a day normally scheduled as his/her day off and has otherwise worked a regular schedule during the workweek (sick, personal, vacation and holiday time are considered part of the workweek), such employee shall be paid at the rate of time and one-half his/her base pay.

C. Whenever an employee is required to appear in court for a job-related incident at a time other than his/her regular duty hours, s/he shall be paid time and one-half for

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the time spent in court.

7. Salaries/Compensation

Effective on the following dates, all employees covered by this Agreement shall receive the following increases to the base salary :

Effective January 1, 1997 - 4% increase to the base salary.

Effective January 1, 1998 - 0% increase for those with a base salary of $65,000. or more.
2% increase for those with a base salary of $64,999. or less.
Effective January 1, 1999 - 3% increase to the base salary.
Effective January 1, 2000 - 3% increase to the base salary.
Effective January 1, 2001 - 3% increase to the base salary.
Effective January 1, 2002 - 3% increase to the base salary.

Courthouse Officers	1/1/97	1/1/98	1/1/99	1/1/00	1/1/01	1/1/02
Step 1	22,000	22,440	23,113	23,806	24,520	25,256
Step 2	25,756	26,271	27,059	27,871	28,707	29,568
Step 3	33,064	33,725	34,737	35,779	36,852	37,958
Step 4	38.845	39,622	40,811	42,035	43,296	44,595
Step 5	42,480	43,330	44,630	45,969	47,348	48,768
Step 6	46,107	47,029	48,440	49,893	51,390	52,932
Step 7	49,741	50,736	52.258	53,826	55,441	57,104
Step 8	54,524	55,614	57,283	59,001	60,771	62,594

Corrections & Patrol Officers	1/1/97	1/1/98	1/1/99	1/1/00	1/1/01	1/1/02
Step 1	22,000	22,440	23,113	23,806	24,520	25,256
Step 2	25,756	26,271	27,059	27,871	28,707	29,568
Step 3	33,066	33,727	34,739	35,781	36,854	37,960
Step 4	39,024	39,804	40,998	42,228	43,495	44,800
Step 5	43,211	44,075	45,397	46,759	48,162	49,607
Step 6	47,397	48,345	49,795	51,289	52,828	54,413
Step 7	57,162	58,305	60,054	61,856	63,712	65,623

All E.M.T.'s will be paid an additional $1,000 per year incorporated in the base salary. This additional $1,000. will cease immediately if the employee fails recertification

8. Increments and longevity
During the term of this agreement, increments to which the employees are entitled shall be awarded as follows:

A. All employees whose anniversary date falls between January

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1 and June 30 shall receive the increment to which they would have been entitled on their anniversary date, retroactive to January 1 of the contract year.

B. All employees whose anniversary date falls between July 1 and December 31 shall receive the increment to which they would have been entitled on their anniversary date, retroactive to July 1 of the contract year.

Longevity pay shall be determined by *length of employment as follows:

A. 2% of base pay at the beginning of seven (7) years;
B. 4% of base pay at the beginning of ten (10) years;
C. 6% of base pay at the beginning of fifteen (15) years;
D. 8% of base pay at the beginning of twenty (20) years;
E. 10% of base pay at the beginning of twenty-five (25) years.

* As of January 1, 1992, length of employment for all new employees will be determined by length of service with Passaic County.

9. Night Differential

Employees working on shifts whose working hours fall between 3:00 PM and 7:00 AM shall receive, in addition to their regular pay, an additional ten (10) percent of their base salary which shall be incorporated in the base pay. This 10% night differential shall be divided equally into the number of pay periods in each year, and said amount, incorporated into the base salary, shall be paid each regular pay. Said amount shall also be paid to all employees working the second and third shifts when on vacation, personal, sick and holiday leave.

An additional ten (10) percent may also be paid to employees who do not strictly fall into the above categories if their responsibilities sometimes call for odd hours, and if authorized by the Sheriff or his designated representative.

Effective 1/1/00, the current night differential paid to employees working the 11:00pm to 7:00am shift, will decrease to 5% for all new employees hired after 1/1/00.

10. Uniform Allowance, Court Papers and Sequestered Jury Service

A. Uniform Allowance

Such allowance is for the purpose of purchasing and maintaining work clothing. It is to be paid in one (1) installment on or about January 1, but no later than January 30,1997 . However as of Janaury 1,1998, the amounts listed below will be incorporated in the base pay yearly, in equal installments.

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	Officers
January 1,1997	$1,275.
January 1,1998	$1,275.
January 1,1999	$1,275.
January 1,2000	$1,325.
January 1,2001	$1,375.
Janaury 1,2002	$1,425.

It is also duly noted that any change in the uniform of the day shall open negotiations for an increase to this amount if the County of Passaic does not provide for the equipment that was changed.

B. Service of Court Papers

1. Serving Papers

Those members of PBA 197 who serve subpoenas after regular working hours will receive a flat rate per week equivalent to five hours at straight time.

2. Mileage

All members of the bargaining unit who utilize their vehicles for county business on a regular basis will be reimbursed at a rate of .25 per mile.

C. Sequestered Jury Service

A sequestered jury is one which is placed in the custody of an officer and taken from the courthouse to be fed and housed overnight. An officer assigned to duty with a sequestered jury shall be compensated as follows:

1. Except for the employee designated as nightman, provided the employee has been on duty during the regular workday, s/he shall be paid overtime at a rate of time and one-half only for all hours worked on sequestered jury duty beyond the regular workday.

2. If the employee has not been on duty during the regular workday, service with the sequestered jury shall considered his/her basic workday and shall be paid in accordance with the established rate.

3. The employee designated as nightman shall be paid overtime at the rate of time and one-half for all hours worked beyond his/her basic workday.

11. Vacation, Sick, Personal and Death Leaves

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A. Vacation Leave

Provided vacation requests are submitted by Jan. 15th each year, such requests will be granted on the basis of seniority of service within each division (patrol, corrections, courthouse) of the Passaic County Sheriff's Department. If an employee requests time off on a holiday, and it is granted, no additional time off will be granted for being on vacation, etc.. on a holiday.

Vacation time shall be granted as follows:

Years of Service :	Working Days Vacation Each Year :
1-5 years	12
6-10 years	15
11-15 years	18
16-20 years	20
over 20 years	22

It shall be duly noted that at no time shall an Officer have more than two (1) years vacation time accumulated without permission from the division head. An employee who becomes ill during vacation leave shall be charged sick time. The employer may demand a doctor's certification.

B. Sick Leave

1. Every employee covered by this Agreement shall earn payment for absence due to illness at a rate of fifteen (15) days per year, which shall accumulate at the rate of 1.25 days per month. Unused sick days shall be cumulative from year to year.

2. After an employee has used ten (10) or more sick days in any calendar year, the Employer shall have the right to demand that the employee furnish a doctor's note to the effect that the employee was, in fact, ill.

3. After the employee has used five (5) consecutive sick days, the Employer shall have the right to demand that the employee furnish a note from his/her doctor that the employee was, in fact, ill.

C. Personal Leave

Every employee covered by this agreement shall be allowed three (3) days personal leave with pay per year, provided that the

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division head be notified of such leave at least three (3) days in advance, except in emergency situations. Approval of such leave request by the division head shall not be unreasonably withheld. Such leave shall not be cumulative from year to year, however, all unused personal days shall be paid to such employee at the end of the year, if the days were denied.

D. Death Leave

Every employee covered by this Agreement shall be allowed three (3) days leave per death for use in the event of death in the immediate family of the employee.

For the purpose of this section, the immediate family is defined as the employee's spouse, children, parents, siblings, grandparents, grandchildren, mother-or father -in - law, sister- or brother- in- law; son or daughter in- law, or a member of the employees's immediate household. An additional day shall be given in the event of the employee's spouse or children's death.

E. Sick Time Cash In Retirement Benefit

Upon retirement, all employees shall receive payment for accumulated sick time in the amount of fifty (50) percent of the accumulated sick time with a maximum amount of $15,000.

12. Holiday Compensation

A. The following days are recognized paid holidays:

1/2 Day New Year's Eve
New Year's Day
Martin Luther King's Birthday
Lincoln's Birthday
Washington's Birthday
Good Friday
Memorial Day
Columbus Day
Independence Day
Labor Day
Election Day
Veteran's Day
Thanksgiving Day
Day after Thanksgiving
1/2 Day Christmas Eve
Christmas Day

B. Those employees having a 4 & 2 workweek shall be paid at thee rate of double their base salary whenever their regularly scheduled workday falls on a recognized holiday, providing they did not call in sick the day before or the day after the Holiday. Those employees having a 5 & 2 workweek as defined herein shall

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be compensated as follows:

1. Recognized holidays that fall on a Saturday shall be celebrated on the preceding Friday.
2. Recognized holidays that fall on a Sunday shall be celebrated on the succeeding Monday.

C. In the event that B1 or B2 is countermanded by the sheriff and/or order of the courts requiring the services of employees, the affected employees shall be granted equal compensatory time off in recognition of the holiday.

13. Criminal/Civil Actions

A. Legal defense of officers

The county of Passaic shall be responsible for all judgments, attorney fees and costs, whether criminal or civil in nature, which directly or indirectly arise out or in the course of employment, of any employee covered by this Agreement.

B. The County represents that it maintains appropriate and sufficient insurance to cover any and all damages resulting from judgements rendered in civil action brought against an employee for any unintentional act or omision arising out of and in course of the employee's performance of duties.

C. The minimum counsel fees for employees, in connection with civil litigation or criminal charges arising within the scope of their employment, shall be :

Non-indictable criminal offenses	$120.00 per hour
Defense in civil matters	$120.00 per hour
Defense in criminal matters	$120.00 per hour

Plus the following disbursement:

1) required transcripts
2) required expert fees
3) court cost and fees

It is noted prior to retaining any attorney, that the attorney must be in agreement with the County of Passaic's fee schedule, or the employee may be liable for the difference.

14. Payment for Education/Continuing Education

A. The county represents that time off without penalty shall be granted to those employees enrolled in approved law enforcement related training courses, subject to the needs of the employer.

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B. Any employee who enrolls in and attends a course in law enforcement related studies at an accredited institution or college approved by the Middle State Association Colleges and Secondary Schools, shall be paid $20.00 per credit, yearly.

All the aforementioned courses must be approved in advance by the sheriff and shall be paid during the first quarter of the calendar year. In addition, those employees who have attained, or hereafter attains a college degree, shall receive an annual educational increment as follows:

Associate Degree--$200.00
Bachelor Degree---$400.00

Only one degree is payable at a time.

15. Medical Benefits

A. The employer will continue to provide and pay for medical hospitalization, and major medical insurance coverage (presently IDA)
Deductable amounts are as follows :
$200.00 deductible per person
$400.00 deductible per family.

In addition,anyone hired after February 1, 1992 will have coverage stated above under IDA Wraparound Program. (See attached.) All covered medical bills will be paid w/in 45 days.

Upon retirement, the Employer will continue to provide and pay for the above programs. The Employer reserves the right to select the insurance carrier who shall provide such benefits, as long as the benefits are equivalent to or better than those provided by the policies in effect on the date of this agreement.

B. Dental Coverage

(see attached)

C. Pre-Paid Prescription Plan

All employees covered under bargaining unit shall be entitled to a pre-paid prescription plan paid for by the County of Passaic. The coverage shall be for members and their families. The maximum deductible shall be $5.00 per prescription on namebrands and $0.00 for generic brands.

D. Disability Plan

The county shall provide a disability plan for each employee. At present, this is a self-funded plan using the State of New

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Jersey guidelines. As of January 1, 1997, these benefits are two-third of your pay per week; the maximum benefit is $ 350.00 per week for a maximum period of twenty-six (26) weeks. There are no extensions. After twelve weeks the employee is responsible for paying the monthly premiums listed below :

	Single	H/W	Family	P/C
Hospitalization ---	$301.64	$580.05	$691.91	$435.74
Prescription-------	$ 32.25	$ 74.54	$ 74.54	$ 39.27
Dental---(Delta)---	$ 16.15	N/A	N/A	N/A
Dental--(Flagship)-	$ 10.76	N/A	N/A	N/A
Life Insurance ----	$ 2.04	N/A	N/A	N/A

E. Work Incurred Injury

Where an employee covered under this Agreement suffers a work-related injury or disability the Employer shall continue such employee at a full pay during continuance of such employee's inability to work.

During this period of time, all temporary disability benefits accruing under the provisions of the Worker's Compensation Act shall be paid over to the Employer. Injury or illness incurred while the employee is attending an employer-sanctioned training program shall be considered in the line of duty.

E. Life Insurance

The employer will continue to provide and pay for life insurance policy for each employee in the minimum amount of $4000.00. In the event the employee dies while employed by the County of Passaic, said death benefit to be increased to $12,000 providing the employee has enough accumulated sick time the paying for half of it would raise it to $12,000. If not, it will be paid proportionately.

16. Miscellaneous

A. The employer shall not change or supplement this Agreement without first having notified and discussed the impasse of such modifications, changes or supplement with PBA officer representatives.

B. Should any portion of this Agreement be held unlawful or unenforceable by any court of competent jurisdiction, such decision of the court shall only apply to that specific portion of the Agreement affected by such decision of the court, whereupon that parties agree to immediately negotiate a substitute for the invalidated portion thereof.

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C. Except as otherwise provided herein, all benefits which employees have heretofore enjoyed and are presently enjoying shall be maintained and continued by the county during the term of this agreement. The personnel policies and regulations of this department, established for all employees of all divisions, which have mutually agreed upon and are in effect, shall continue to be applicable to all officers except as otherwise provided herein.

D. The county agrees that it shall not discriminate against any officer during the term of this agreement with respect to hours, wages, or terms of or conditions of employment, including loss of income, change of assignment or demotion, by reason of his/her membership in the New Jersey Policemen's Benevolent Association and its affiliates participating in any activities, collective negotiations with the county, or institution of any grievance, complaint, or proceeding under this Agreement or otherwise with respect to any terms and conditions of employment.

E. The County of Passaic agrees to make available to the union in response to reasonable request from time to time, all available information in the public domain.

F. Whenever any representative of the union is scheduled to participate in negotiations, grievances, conventions or any PBA business during work hours, s/he shall suffer no loss of pay provided a written request is submitted for approval prior to the event.

G. Employee seniority shall be based upon length of continuous, permanent service in the Passaic County Sheriff's Department. Elapsed time on leave without pay shall be deducted therefrom. All appropriate Civil Service laws, rules and regulations shall apply.

H. The Employer agrees to deduct the PBA's monthly membership dues from the pay of those employees who authorize such deductions in writing, pursuant to N. J. S. A. 52:15-15.9e. The amounts so deducted shall be remitted to the PBA by the tenth day of the succeeding month after which deductions are made, together with a list of names of the employees whom deductions are made.

I. As of the effective date of this agreement, any permanent employee in the bargaining unit who does not join the Union within thirty (30) days of initial employment, and

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any permanent employee previously employed within the unit who does not join within the ten (10) day reentry into employment with the unit shall , as a condition of employment, pay a representation fee to the Union by automatic payroll deduction. The representation fee shall be an amount equal to eighty-five (85) percent of the regular Union membership dues, fees and assessments as certified to the Employer by the Union. The Union may revise its certification of the amount of representation fee at any time to reflect changes in the regular Union membership dues, fees and assessments.

J. Retirement

All employees covered under this Agreement should apply three (3) to six (6) months prior to retirement at the County Personnel Office. The employee must bring the following:

1. employee's birth certificate;
2. birth certificate of the employee's spouse;
3. marriage certificate;
4. divorce papers, if applicable;
5. birth certificate of any child under the age of eighteen

The retirement benefits are explained in the attached PFRS and PERS Pension Booklets. The County of Passaic shall continue to provide and pay for medical/hospitalization & prescription coverage & for all retired employees in the bargaining unit as outlined in the attached Medical Coverage Booklet addendum

It is noted, upon application for retirement, that the employee may not be out without a doctor's note for more than one hundredtwenty (120) working days prior to retirement.

The County of Passaic shall pay in full, all medical & prescription premiums (see 15 A & C) for all members who retire with 25 years of service or more. For those members who retire with less than 25 years of service, the employee shall pay the following monthly amount to the County of Passaic toward Medical coverage premiums:

Monthly Medical & Prescription Coverage Premiums

For single coverage -$ 45.66
For Husband/Wife-----$ 82.90
Family----------$102.86
Parent & Child-------$ 68.82

All members who file for retirement during the term of this Agreement, shall be fully vested with all the terms of this Agreement, including but not limited to wages, medical, prescription or any other terms or conditions listed herein. Said benefits and the retirees entitlement thereto, shall be unaffected by future changes to subsequent contracts. This provision shall survive the expiration of the collective negotiations agreement.

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K. "ON-DUTY" STATUS
While on any volunteer SERT detail, including training, the-the employee is considered "on-duty" for insurance, pension, etc.. purposes, however, no payment of overtime, straight time, etc...is paid whatsoever.
PBA Members who work PBA jobs are considered "on-duty" for pension purposes, providing the money is paid thru the County payroll.

L. The County of Passaic will continue the practice, that, where work projects are conducted on county roads & security is required for traffic control, etc...the primary entity in providing those services, will be PBA Local # 197. The engineering department will notify all contractors, when permits are issued, to contact PBA 197 for their security needs. All monies paid to employees must be paid thru the County payroll at a rate as may be mutually agreed upon but not less than $25.00 per hour.

PERIOD OF AGREEMENT

This Agreement shall become effective & retroactive to January 1, 1997 and shall remain in full force and effect until December 31, 2002 or until a successor Agreement is negotiated and executed, whichever shall last occur.

In Witness whereof, the parties hereto have caused these presents to be signed by their proper Officials and duly considered Officials, this _____ th day of _____, 1997.

FOR THE COUNTY OF PASSAIC:

Ed Engelhardt
Sheriff

FOR PBA LOCAL # 197

Harry Gromb - President
PBA Local # 197

Nicola R. Di Donna
County Administrator

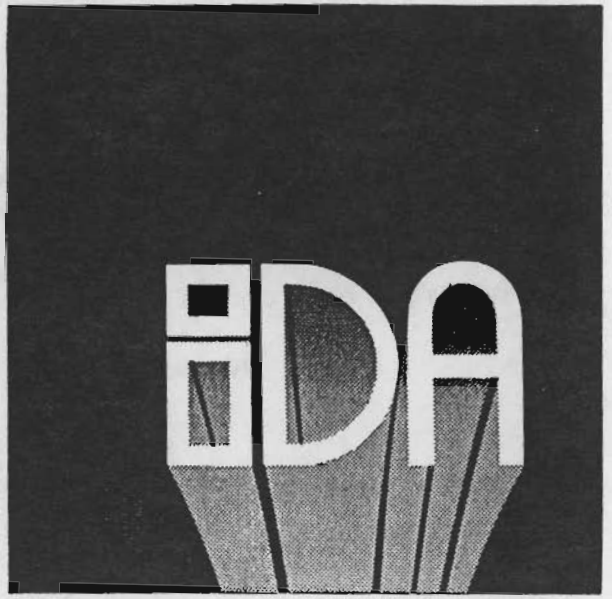
PASSAIC COUNTY HEALTH BENEFITS PROGRAM

800-446-9972

3 Post Road, Oakland, New Jersey 07436 • 201/ 337-0555 • 609/ 344-4840

1480 Baltimore Pike, Suite 213, Springfield, Pennsylvania 19064 • 215/ 543-8312

$200 Deductible



Introduction

Your health care program gives you broad protection to help meet the costs of most illnesses and injuries.

In this booklet you'll find the important feature of your group's health care program provided by Insurance Design Administrators (IDA).

You should read this booklet carefully so that you know the health care benefits available to you and your family.

This booklet replaces any booklets or certificates you may have received previously.

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SUMMARY PLAN DESCRIPTION

The information furnished herein is designed to acquaint you with the benefits of your Plan which are now available to you and your covered dependents.

GENERAL INFORMATION

Plan Sponsor:	County of Passaic 317 Pennsylvania Avenue Paterson, NJ 07503
Name of Plan:	The Plan shall be known as the County of Passaic Employee Health Care Plan.
Plan Administrator:	County of Passaic
Address of Plan:	317 Pennsylvania Avenue Paterson, NJ 07503
Plan Effective Date:	October 1, 1992
Plan Fiscal Year Ends:	September 30,
Plan Supervisor:	Insurance Design Administrators 3 Post Road Oakland, N.J. 07436 1-(800)-225-1345 (201)-337-0555 (609)-344-4840
Contributions:	Non-Contributory
Average Work Week Requirements:	35 hours
Dependent Children's Coverage:	Unmarried children are covered until the end of the calendar year in which they attain age 23.
Change Date:	First of the month following date of change.

Termination Date: Last day of the month following the date of termination

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the plan benefits (including any limitations and exclusions), the procedures to be followed in presenting claims for benefits, and remedies available for redress of claims denied are in the Plan Document.

Definitions

This section defines certain important words used in this booklet. The meaning of each defined word, whenever it appears in this booklet, is governed by its definition as listed in this section.

We, Us, Our and the Plan. Insurance Design Administrators.

Approved Hospital. A health care facility licensed by the State of New Jersey to provide hospital care and services, or one which meets the same standards if located in another state.

NOTE: Nursing homes; rest homes; health resorts; institutions for the aged; infirmaries; places primarily for domiciliary care, custodial care, drug addiction, pulmonary tuberculosis; or other institutions providing non-medical services are not approved hospitals.

Government Hospital. A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county or city hospital.

Detoxification Facility. A health care facility licensed as a detoxification facility by the State of New Jersey, or one which meets the same standards if located in another state.

Residential Facility. A health care facility licensed, certified or approved for treatment of alcoholism by the State of New Jersey, or one which meets the same standards if located in another state.

Surgical Center. An ambulatory care facility licensed as such by the State of New Jersey to provide same-day surgical services or one which meets the same standards if located in another state.

Approved Hemophilia Treatment Center. A health care facility licensed by the State of New Jersey for the treatment of hemophilia or one which meets the same standards if located in another state.

Skilled Nursing Facility. A health care facility or a designated part of a hospital which provides skilled nursing care and related treatment.

Home Health Care Agency. An agency which provides skilled nursing and other related treatment in a patient's home.

Hospice. A hospice care program which is approved by either the Joint Commission on Accreditation of Hospitals or Medicare.

Birthing Center. A facility which provides obstetrical services to eligible persons as a cost saving alternative to hospital inpatient care.

Physician. A doctor who is licensed to practice medicine and surgery. This includes both doctors of medicine and osteopathy. Physician also includes doctors of dental surgery, doctors of podiatry, doctors of chiropody, bioanalytical laboratory directors, licensed psychologists, certified nurse-midwives, registered physical therapists, physician anesthesiologists and licensed chiropractors.

Certified Registered Nurse Anesthetist (CRNA). A registered nurse, certified to administer anesthesia, who is employed by and is under the supervision of a physician anesthesiologist.

Benefit Month. The monthly period starting with the date shown on your identification card.

Benefit Year. The 12-month period beginning on the date shown on your identification card.

Service Report. The claim form which we need to process a claim for physician's services.

When the term "facility" is used in this booklet it can mean a hospital, detoxification facility, residential facility, surgical center, skilled nursing facility, home health agency or other facility we approve as eligible.

General Information

How to Enroll

You may enroll in the IDA health care program by completing an enrollment form. If you enroll your dependents, their coverage will become effective on the same date as your own. If you don't apply for coverage for yourself or your dependents when you first become eligible, you must wait for a later open enrollment period to enroll.

Your Identification Card

You will receive an identification card to show to the hospital, physician or provider when you need to use your benefits. Your identification card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can start to use your benefits. All of your eligible dependents share your identification number.

Always carry this card and use your identification number when you receive covered services. If you lose your card, you can still use your coverage if you know your identification number. The inside back cover of this booklet has space to record your identification number along with other information you will need when making inquiries about your benefits. You should, however, contact your enrollment official immediately to replace the lost card.

You cannot let anyone not named in your coverage use your card. Nor can you let anyone who is not named in your coverage use your benefits or receive payment for them.

When Benefits Begin

Your benefits begin on the effective date shown on your identification card. However, any eligible person who is in a health care facility when coverage would normally start will not receive Hospital benefits under this program during that stay. Medical-Surgical benefits will be available for services performed on and after the effective date, as long as they are not related to surgical services that were performed before that date.

For Major Medical Only
If, at the time coverage under this program would otherwise begin, (1) you are not actively at work for your employer, coverage for you and your dependents will not begin until the first day of the benefit month following your return to work; or

(2) a dependent is confined in a hospital, the dependent's coverage will not begin until the day following that dependent's discharge from the hospital.

Types Of Enrollment Available

You may enroll under the following types of coverage:

- Single - provides coverage only for yourself;
- Parent and Child(ren) - provides coverage for you and your eligible children but not your spouse;
- Family - provides coverage for you, your spouse and your eligible children.

Eligible Dependents

Your eligible dependents are your spouse and your unmarried children under age 23. We consider your children dependents if they are your own, your spouse's natural children, your legally adopted children or a child placed in your home for whom you have begun adoption procedures, or children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible. Foster children are not included.

Although a child born to unmarried parents is eligible to be enrolled as a dependent, the child must reside with you. The residency requirement may be waived if a court decree makes you financially responsible for the child's health care expenses. Also, if the child's last name is different than yours, a birth certificate naming you as parent must also be received by us.

Coverage for a child ends on the last day of the benefit month in which the child marries or the last day of the calendar year in which the child attains age 23, whichever comes first.

In addition, an unmarried handicapped child may remain covered beyond age 23. A handicapped child is one who is incapable of self-sustaining employment because of mental retardation or physical handicap. The child's handicap must have started before he or she became age 23, and the child must depend chiefly on you for support.

For the handicapped child to remain covered, you must give us proof of the child's incapacity within 31 days from the end of the calendar year in which the child becomes 23. The proof must be in a form which meets our approval.

Once we receive acceptable proof of the handicap, that child can remain covered as long as the Family or Parent and Child(ren) contract is in effect and the handicap

continues to exist. Coverage will end on the last day of the benefit month in which the child ceases to qualify as a handicapped child.

Change In Type Of Coverage

If you want to change your type of coverage, see your enrollment official. If you marry, you should arrange for enrollment changes within 60 days before or after your marriage.

If you gain or lose a member of your family or whenever someone covered under this program changes family status, you should check this booklet to see if coverage should be changed. This can happen in many ways: for example, through the birth or adoption of a child, or the divorce or death of a spouse.

- If you already are enrolled under Family or Parent and Child(ren) coverage, your newborn infant is automatically included;
- If you have Single coverage, your newborn will be eligible from the date of birth if you apply for Family or Parent and Child(ren) coverage within 31 days of birth;
- If you apply for coverage for your newborn between the 32nd and 90th day after the birth, the coverage will be effective on the first day of the benefit month after the date the application was received.

When Your Coverage Ends

Your coverage ends on the last day of the benefit month in which your enrollment in this program ends.

If your enrollment in this program ends, you may continue Hospital and Medical-Surgical protection. You simply transfer to our direct payment coverage.

However, your benefits will not be continued under direct payment coverage if your group's program with us is replaced by another group insurance program.

For the Major Medical program, there is no conversion opportunity available. You may apply directly to us for direct payment Major Medical coverage. The change will be made in accordance with our underwriting rules and regulations in effect at the time of the change.

Coverage for a child ends on the last day of the benefit month in which he or she marries or in the case of an unmarried child, at the end of the calendar year in which he or she reaches the termination age.

When your child marries or is no longer eligible as a dependent, he or she also may transfer to direct payment coverage. The child should take prompt action to obtain this separate coverage. To assure continued coverage, an application should be sent directly to Insurance Design Administrators, P.O. Box 875, 3 Post Road, Oakland, New Jersey 07436 and received by the Plan within 31 days of the date on which your child's coverage will end.

Benefits After Termination

If you or any of your dependents are receiving covered inpatient care at the time your coverage ends, benefits will be available for eligible services provided during the uninterrupted continuation of that stay, but only to the extent that benefits remain.

Extension Of Coverage Due To Group Termination

If you or any of your dependents are totally disabled on the date your group's coverage under this program ends, Hospital and Medical-Surgical benefits will continue to be available for that person, for treatment directly related to the disability only. However, benefits will not be extended beyond (1) 90 days from the date on which your group's coverage ended, (2) the date the disability ends, or (3) the extent benefits remain when the program ends, whichever comes first.

Major Medical benefits will also continue to be available for covered medical expenses resulting from the sickness or injury that caused the disability during the uninterrupted continuation of the disability. However, benefits will not be extended beyond (1) the date the disability ends, (2) 12 months from the date the group coverage ends, or (3) the extent that benefits remain when the program ends, whichever comes first.

If You Leave Your Group Due To Total Disability

If you can no longer be employed due to a total disability, you can arrange to continue coverage through your group (including coverage for dependents) if:

- You were continuously enrolled under the group program for the three months immediately prior to your loss of employment;
- You notify your employer that you want to continue your group coverage within 31 days of the date your coverage would normally end;
- You continue to pay any premiums required for the coverage by your employer.

However, continued coverage under this program for you and your eligible dependents will end at the first to occur of the following:

- Failure by you to make timely payment of any contribution required by your employer. If this happens, coverage will end at the period for which contributions were made;
- The date you become employed and eligible for benefits under another employer's health plan or, in the case of an eligible dependent, the date the dependent becomes employed and eligible for such benefits;
- The date this program ends.

If you are a totally disabled former employee whose group coverage (including coverage for any eligible dependents) has been continued without interruption in accordance with state law, through the employer's prior health insurance carrier, you will also be eligible for coverage under this program. Such coverage will be continued until the former employee no longer meets the eligibility requirements described above.

Totally disabled means that due to injury or illness, as determined by us:

- You are unable to engage in your regular occupation and are not, in fact, engaged in any employment for wage or profit; or
- Your dependent is unable to engage in the normal activities of a person of like age and sex in good health.

Continuing Protection For Surviving Dependents

Eligible dependents of a deceased subscriber may have coverage continued under this program for at least 180 days after the subscriber's death. See your enrollment official for further details and to arrange to make any required premium payments through the group.

When 180 days of group coverage ends, any eligible dependents may transfer to direct payment coverage.

Extension Of Coverage Due To COBRA

If any of the following events occur, you and your eligible dependents may have the opportunity to continue group health coverage which would otherwise end:

- Termination of employment;
- A reduction of your hours so that you or your dependent(s) no longer meet the eligibility requirements for coverage;
- Your death;
- Your legal separation or divorce;
- Your enrollment in Medicare;
- Your child no longer qualifies as a dependent.

You must pay the required premiums to maintain your coverage. If you and/or your eligible dependent(s) elect to continue coverage, it would be identical to the health care coverage for your group and would be extended as follows:

- Up to 18 months in the event of the termination of your employment or a reduction in your hours such that you no longer meet the eligibility requirements of your group's program;
- Effective December 19, 1989, up to 29 months for qualified beneficiaries Social Security determines were disabled at the time of employment termination or reduction in hours;
- Up to 36 months for your dependent(s) in the event of your death, your legal separation or divorce, if you become enrolled in Medicare or if your child no longer qualifies as a dependent.

You and your dependents also have the option to transfer to direct payment Hospital and Medical-Surgical coverage at the end of this extended period of coverage. For the Major Medical program there is no conversion opportunity available. You may apply directly to us for direct payment Major Medical coverage. This change will be made in accordance with our underwriting rules and regulations in effect at the time of the change. See your enrollment official for details on eligibility.

Medical Necessity

We will make payment for benefits under this program only when:

- Services are performed or prescribed by your attending physician;
- Services, in our judgment, are provided at the proper level of care (inpatient, outpatient or out-of-hospital);
- Services or supplies are medically necessary for the treatment and diagnosis of an illness or injury.

THE FACT THAT YOUR ATTENDING PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY FOR THE TREATMENT AND DIAGNOSIS OF AN ILLNESS OR INJURY OR MAKE IT AN ELIGIBLE MEDICAL EXPENSE.

Cost Containment Program

If we determine that an eligible service can be provided in a medically acceptable, cost-effective alternative setting, we reserve the right to provide benefits for such service when performed in that setting.

Individual Case Management Program

When it appears that you or your eligible dependent will require long-term or extensive care, you or your physician should contact Insurance Design Administrators at (201) 337-0555 or (800) 225-1345.

Individual Case Management is an additional service offered to help subscribers and their physicians plan for a serious illness or disability.

Hospital Benefits

The following section describes the Hospital benefits available under this program.

Hospital Inpatient Care

You are covered for benefits for the following inpatient hospital services when they are consistent with the diagnosis and treatment of an illness or injury:

- Bed and meals, including special dietary service in a semi-private room;
- General nursing service in all facilities of the hospital;
- Services of all hospital employees, interns, residents, technicians and independent contractors when paid by the hospital for providing covered services;
- Use of operating, treatment, delivery and emergency room equipment and facilities;
- Therapeutic solutions, all types of anesthetic agents, oxygen, sera when used as other than blood substitutes or replacements, dressings, bandages, casts and surgically implanted cardiac pacemakers, including batteries, electrodes and their replacements;
- All drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
- Physical therapy;
- Diagnostic X-ray examinations, radioactive isotope studies, laboratory and pathology services;
- Diagnostic studies in connection with Second Opinion Consultations provided under a contract with us. If we decide that the diagnostic studies in connection with Second Opinion Consultations could have been performed safely and effectively on an outpatient basis, benefits will be limited to what we would have paid if you were an outpatient;
- Blood processing services provided by the hospital or by a non-profit blood

supplier for drawing, processing and distributing blood (the cost of blood is not covered);
- Benefits for the cost of breast prostheses in connection with reconstructive breast surgery;
- All other approved hospital facilities and equipment not specifically excluded in this booklet.

Dental Care

We will provide payment for hospital services as either an inpatient or outpatient for extraction of bony impacted molars or impacted bicuspids, for treatment of accidental injuries from external cause, for oral surgery (except extractions which are not impacted molars or impacted bicuspids) or for treatment of malignancy of the mouth. Hospital care during an admission for any other dental service is eligible only if hospitalization is necessary because of a non-dental condition.

Obstetrical Care

We will provide benefits for covered hospital services related to obstetrical care.

Hospital care provided to your newborn child during the initial eligible joint hospital stay of you and your child is covered in your obstetrical care benefits.

Your newborn child will receive separate benefits when the child is enrolled under your type of coverage and is admitted for the treatment of an illness or injury.

Obstetrical care is not available to dependent children under this program.

Birthing Center Benefits

If you are eligible for maternity coverage, there is an alternative to the conventional hospital delivery room care.

Deliveries in birthing centers, in many cases, are considered an effective cost-saving alternative to inpatient hospital care. At a birthing center, deliveries take place in "birthing rooms" where decor and furnishings are designed to provide a more natural, home-like atmosphere.

All care is coordinated by a team of certified nurse-midwives and pediatric nurse-practitioners. Obstetricians, pediatricians and a nearby hospital are available in case of complications. Prospective birthing center patients are carefully screened, and only low-risk pregnancies are accepted. High-risk

patients are referred to a hospital maternity program. At some birthing centers, certified nurse-midwife charges may be excluded from the facility's charges. These charges will be paid in accordance with your Medical-Surgical payment schedule.

Services, including pre-natal, delivery and post-natal care, will be covered in full as long as delivery takes place at one of the centers. If complications occur during labor, delivery may take place in a hospital because of the need for emergency and/or inpatient care. Delivery must occur within 24 hours of the transfer from the birthing center.

If the patient is transferred to a hospital maternity program while receiving pre-natal care, any expenses for pre-natal care incurred at the center will be the responsibility of the patient. **If, for any reason, the pregnancy does not go to term, we will not provide payment to the birthing center.**

Private Rooms

If you occupy a private room in a hospital, you must pay the difference between the private room rate and the average room rate for all semi-private rooms in the same area of service of the hospital.

Pre-Admission Review

Your Pre-Admission Review (PAR) program determines whether all inpatient admissions, except for maternity admissions, are medically necessary or whether an alternate care setting is more appropriate. To help contain the cost of your health care benefits, the Pre-Admission Review program requires that you request Pre-Admission Review in advance of the scheduled admission.

You or your physician should call our Referral Center, MEDIQ, toll-free at 1-800-525-4088 to provide the required information. For emergency admissions, you, a family member, or your physician must notify MEDIQ within 48 hours following the emergency admission. The information is reviewed by physician consultants or registered nurses using medical guidelines. An approval or denial will be provided by telephone and a confirmation letter will be sent to the patient, physician and the hospital.

If denied, this means that the recommended medical treatment does not require hospital confinement and should be rendered at a level of care which is more medically appropriate such as a hospital's outpatient department, a doctor's office or a same day surgery center. You may be liable for up to 100% of the eligible hospital charges if admitted as an inpatient after having received a PAR denial.

If the patient does not contact MEDIQ prior to an inpatient admission, benefits will be reduced as follows:

- If PAR is not obtained, but the admission is medically necessary, this program's payment for eligible charges will be reduced by 20%;
- If PAR is not obtained and the admission is not medically necessary, no benefits will be paid.

Pre-Admission Testing (PAT)

Diagnostic tests which are eligible under your coverage on an inpatient basis also are covered on an outpatient basis before your admission to a hospital. PAT is eligible when you are admitted to a hospital prior to an inpatient hospital stay or prior to ambulatory same-day surgery.

Your doctor decides whether to use PAT. It is covered only if you are scheduled for admission to the hospital for treatment of the diagnosed condition which made the test necessary. However, if your admission does not take place, the testing may still be covered, but only if the admission is postponed or cancelled for at least one of the following reasons:

- The tests show a condition requiring medical treatment before the admission;
- You develop a medical condition that delays the admission;
- A hospital bed is not available on the scheduled date of admission;
- PAT indicates that, contrary to your attending physician's expectation, the admission is not necessary.

PAT benefits are not charged against your equivalent "Rider J" maximums.

Hospital Outpatient Care

This program provides coverage of the same hospital services for outpatients that are eligible for hospital inpatients with the exception of bed and board. Physical therapy and radiation therapy are covered only as shown under the equivalent "Rider J" benefits.

If you use a hospital outpatient department, benefits are provided for the following situations:

- Hospital care required because of an accidental injury;
- Surgery of a cutting or cauterizing nature other than chemical cauterization. Procedures related to obstetrical care are covered only if you are eligible for obstetrical care;

- Surgical diagnostic procedures which we determine must be performed in the outpatient department instead of out-of-hospital (Note: Contact us if you want to know whether a specific surgical diagnostic procedure is an eligible outpatient service);
- Diagnostic studies in connection with Second Opinion Consultations;
- Blood transfusions;
- Application and removal of casts;
- Complete cardiac pacemaker follow-up examinations, but not telephone check-ups;
- Dialysis treatment;
- Removal of implanted orthopedic hardware (nails, screws, plates, etc.);
- Treatment of poisoning;
- Rehabilitation services for treatment of alcoholism under a program approved by the New Jersey Division of Alcoholism or, if the hospital is outside of New Jersey, under a program which meets Joint Commission on Accreditation of Hospitals' standards. Services are limited to an initial diagnostic evaluation, services of individual and group therapy or individual and family counseling.

Equivalent "Rider J" Benefits

Under the equivalent "Rider J" benefits, we will provide benefits for the following additional outpatient hospital services when they are ordered by your physician and performed by a hospital employee.

- X-ray therapy for a proven malignancy, radioactive isotope therapy (non-sealed sources) and chemotherapy following surgical procedures in connection with the treatment of breast cancer. Benefits for these services are provided up to a total of $500 per benefit year;
- Pathology, including laboratory examinations, electrocardiograms, electroencephalograms and other clinical tests approved by us. Benefits for these services are provided up to a total of $50 per benefit year;
- Diagnostic X-rays and radioactive isotope studies. Benefits for these services are provided up to a total of $125 per benefit year;
- Radium, radioactive isotope (sealed sources) or radon therapy. Benefits for these services are provided up to a total of $150 per benefit year;
- Physical therapy. Benefits for these services are provided up to a total of $50 per benefit year.

These dollar limits are the total amount that will be paid for each eligible person in any one benefit year by us for Hospital and Medical-Surgical benefits, either separately or together, for the same type of services. Also, within each category, there is a specific allowance for each type of service performed.

There are no benefits for any test or service in connection with routine physical examinations or check-ups. In addition, the following are not covered: any

procedure involving care of the teeth; research studies; screening; routine tests for hospital admission; floroscopy without films; tests related to pregnancy or to check for pregnancy, regardless of the test findings, of a child dependent; and any other tests or X-rays that are not performed to specifically diagnose an illness or injury.

Home Dialysis Benefits

We will provide benefits for home dialysis when the home dialysis services are provided by and billed for by a hospital, freestanding dialysis center or home health care agency. The facility must make arrangements for training, equipment, rental and supplies on behalf of the patient. We will pay for these services on a per treatment basis.

Each dialysis treatment will be counted as one benefit day. Benefits will *not* be paid for home nursing services in connection with administration of dialysis.

Home Hemophilia Benefits

The following services are provided for home treatment of routine bleeding episodes associated with hemophilia when provided under the supervision of a state-approved hemophilia treatment center:

- Training for self-administration of home treatment;
- Blood products when used as other than blood substitutes or replacements;
- Blood infusion equipment (syringes and needles).

Benefits In Facilities Other Than Hospitals

Surgical Center Benefits

If you have surgical services performed at a surgical center, benefits will be provided for the use of the facility, if the services are considered eligible outpatient hospital services under this program. Procedures related to obstetrical care are covered only if you are eligible for obstetrical benefits.

You must be admitted and discharged within a 24-hour period.

Detoxification And Residential Facility Benefits

Inpatient benefits. We will provide benefits for the following covered inpatient services for the treatment of alcoholism in detoxification and residential facilities:

- Bed and meals in a standard room. If you occupy a special room in a facility that contracts with us, you must pay any additional room charge for the special room;
- All drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
- Laboratory tests, but not X-rays;
- Psychological testing;
- Individual and group therapy and individual counseling;
- Counseling for the family of the person who is receiving covered inpatient services;
- Occupational therapy, but not diversional or recreational therapy or activity;
- Services of employees of the facility.

Ambulatory (outpatient) benefits. We will provide benefits when you receive alcoholism rehabilitation services on an ambulatory basis in a residential facility or as aftercare in a detoxification facility. Benefits are provided for the following services:

- Individual and group therapy and individual counseling;
- Counseling for the family of the person who is receiving eligible ambulatory services;
- Services of staff including the necessary trained professionals.

Skilled Nursing Facility Benefits

You may be transferred to a skilled nursing facility immediately following a covered hospital stay of at least 3 days. The services you receive must be consistent with the diagnosis and treatment of the condition which required your covered inpatient stay. All of your prior stay in the hospital must have been eligible for benefits.

You must be transferred to a skilled nursing facility on the same day you are discharged from the hospital.

Skilled nursing facility services include:

- Semi-private accommodations;
- Up to 30 days are available during each admission;
- The same covered services that are available to hospital patients as described in this booklet, but only if they are available at the skilled nursing facility.

Home Health Care Agency Benefits

You may receive services provided by a home health care agency under the following circumstances:

- You must be homebound;
- You must require skilled nursing care, physical therapy or speech therapy under a plan prescribed by an attending physician and approved by us;
- The services you receive must be consistent with the diagnosis and treatment of the condition which required you to have your eligible inpatient stay of at least 3 days;
- When you transfer to home care services following discharge from a hospital stay or discharge from a skilled nursing facility, all of your prior stay in the hospital or skilled nursing facility must have been eligible for benefits. Also, your home care plan must have been established by your attending physician before your discharge.

Home health care agency services include:

- Part-time skilled nursing service provided by or under the supervision of a registered nurse;
- Physical therapy;
- Speech therapy;
- Any other related treatment and services eligible for hospital outpatient benefits except drugs and administration of dialysis;
- Medical social services or part-time services by a home health aide during the period when you are receiving skilled nursing care, physical therapy or speech therapy;
- Up to 60 visits are available in the 120 days following hospital discharge.

Hospice Care

Benefits for hospice care are available only when such care is provided through a hospice care provider. The care must be provided according to a physician-prescribed course of treatment approved by us for an eligible person with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

A hospice care program is a health care program which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

The following services are eligible under this hospice care program:

- Part-time nursing services of an R.N. or L.P.N.;
- Home health aide services provided under the supervision of an R.N.;
- Medical care rendered by a hospice care program physician;
- Therapy services (including speech, physical and occupational therapies);
- Diagnostic services;
- Medical and surgical supplies (with prior authorization) and durable medical equipment;
- Prescribed drugs;
- Oxygen and its administration;
- Respite care;
- Inpatient acute care for related conditions;
- Medical social services;
- Psychological support services to the terminally ill patient;
- Family counseling related to the eligible person's terminal condition;
- Dietician services;
- Inpatient room, board and general nursing services for related conditions;

Respite care benefits are limited to a maximum of ten (10) days.

Hospice care benefits are not limited to or counted against the benefit days available under the eligible person's basic hospital services.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients.

Payment will be 100% of the provider's reasonable and customary charge up to a $10,000 dollar maximum.

Claim And Payment Information

Payment For Hospital Benefits

The following payment provisions apply to hospital, surgical center, detoxification facility or residential facility charges:

- Charges incurred for inpatient and outpatient services are covered under this program

We will pay hospitals operated by the United States government only if:

- Services are for treatment on an emergency basis for accidental injury from external cause;
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Whom We Will Pay

We will pay all approved hospitals directly for inpatient claims. If you are admitted as an outpatient, we will reimburse you for eligible expenses.

If you pay a facility for services covered under this program, reimbursement may be made directly to you for the amount we would be required to pay the provider. Send the itemized bill to Insurance Design Administrators, P.O. Box 875, Oakland, New Jersey 07436.

If, for any reason, the claim you submit to us is not eligible, you will be notified of this within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section of this booklet.

Benefit Days Available

We will pay for eligible care, up to the number of days listed below, but only to the extent we determine such care is medically necessary.

Benefit Days

For inpatient care for general conditions:

- 120 full benefit days;
- Every two days in a skilled nursing facility or every three home care visits will count as one benefit day for inpatient care;
- 245 part benefit days after full benefit days have been used unless the admission is for any of the conditions described below.

For inpatient care of special conditions:

- 20 benefit days for any one more of the following conditions and their after-effects: tuberculosis, contagious diseases, mental, psychoneurotic and personality disorders;

- These days are eligible only as part of the benefit days available to you for general conditions.

For inpatient care in governmental hospitals:

- 20 benefit days in governmental hospitals located outside of New Jersey. This does not apply to retired Military Personnel;

- These days are eligible only as part of the benefit days available to you for general conditions.

Your outpatient days are part of your available inpatient days. Each day of outpatient care reduces by one day your available inpatient days.

Renewal of Benefit Days

Benefit days will be renewed on the date your new benefit year starts, provided that, for related conditions, 90 days or more have passed from the date on which inpatient or home care services were last received from an eligible provider.

If you are in a facility or receiving home health care agency services at the time your benefit days would renew, you will be covered only for the unused number of days from the benefit year in effect when the admission occurred.

Medical-Surgical Benefits

The following section describes the Medical-Surgical benefits available under this program.

Surgical Services

Cutting or cauterizing surgery and the setting of fractures or dislocations are covered at approved hospitals on either an inpatient or outpatient basis or at approved freestanding surgical centers. Outpatient coverage includes the application of casts for any condition, blood-transfusions and paracenteses.

When surgical service is needed because of an accidental injury, it is covered at approved hospitals on an inpatient or outpatient basis or at approved freestanding surgical centers. Emergency surgery for accidental injury also is covered wherever it is performed. If it's given outside a hospital or a freestanding surgical center, the surgical service must take place within 48 hour after the accident.

The removal of tonsils and/or adenoids is covered regardless of where the service is performed.

Certain diagnostic surgical procedures are covered at approved hospitals on either an inpatient or an outpatient basis.

Under the equivalent "Rider J" benefits, we also will make payments for surgical services of a cutting or cauterizing nature and certain surgical diagnostic procedures when performed by an eligible physician elsewhere than [redacted] hospital.

Anesthesia Service

Benefits are provided for the administration of general (not local) anesthesia by a physician anesthesiologist, or by a Certified Registered Nurse Anesthetist employed by and personally supervised by a physician anesthesiologist.

Dental Surgical Service

Dental surgery (surgical service to the alveolar processes, gums, cheeks, jaws or mouth, or to one or more teeth) is covered wherever it is performed and meets at least one of the following conditions:

- It must be necessary because of an accidental injury, and must take place within 48 hours after the accident; or
- It must involve surgical services that are recognized as common to both the medical and dental professions, such as setting a fractured jaw.

Dental surgery is covered when it is performed in a hospital on either an inpatient or outpatient basis for the extraction of one or more bony impacted teeth, or treatment of a malignancy of the mouth.

Important note: Many dental procedures are specifically excluded from coverage under this program. They are discussed in the "Exclusions" section of this booklet.

In-Hospital Medical Services

We will provide for visits by a physician to a hospital inpatient. The visits must be for necessary medical treatment of a diagnosed condition. Care of healthy newborn children is covered when provided by a doctor who was not involved in the delivery service. There are limits on the number of days covered for in-hospital medical services. The following rules help us apply these limits:

- A hospital stay is any uninterrupted time spent as a hospital inpatient. In counting the number of days in a hospital stay, each calendar day, or portion of a day counts as one day;
- Each calendar day when a covered inpatient receives in-hospital medical service counts as one day of this service;
- When hospital or skilled nursing facility stays are close together, they can count as one confinement, whether or not they're at the same hospital or skilled nursing facility. Only when an admission is at least 90 days after the eligible person's last covered day of hospital or skilled nursing facility confinement, does the new stay count as a new confinement;
- Benefits for medical services will be fully renewed when at least 90 days elapse from the last date for which benefits were provided for in-hospital

medical service, skilled nursing facility service or home health agency service, and you are readmitted to an approved hospital.

Services Of Hospital-Employed Physicians

Your Medical-Surgical program includes coverage for the following services performed on an inpatient basis when you are billed directly for these services by any hospital-employed physician specialist:

- Preparation and interpretation of electromyograms and nerve conduction studies;
- Interpretation of electrocardiograms, electroencephalograms and other graphic studies; and
- Anatomical pathology.

Benefits will be provided for the same services on an outpatient basis if they are performed in connection with accidental injury, surgery of a cutting or cauterizing nature, eligible diagnostic procedures or the initial diagnostic evaluation of alcoholism.

If the services are performed on an outpatient basis, but are not in connection with any of the situations listed above, benefits will be subject to the benefit year maximums for diagnostic laboratory examinations under your equivalent "Rider J" benefits.

Charges from hospital-employed physician specialists who do not bill you directly for the above services are eligible under your Hospital program.

Medical Visits For General Days

In-hospital medical services are available for up to 365 continuous calendar days of each hospital confinement for anyone covered under this program.

Medical Visits For Special Conditions

These limits apply for in-hospital medical services for the following conditions:

- 30 days of in-hospital medical services for the treatment of mental disorders, including psychoneurotic, or personality disorders, or drug addiction;
- 30 days on in-hospital medical services for the treatment of tuberculosis.

Benefits for these conditions depend on the number of remaining eligible in-hospital medical days. They are not in addition to the days available for general conditions.

What if an eligible person is transferred from one hospital to another, or from a hospital to a skilled nursing facility? When this happens, we count it as one continuous hospital stay in applying the limits above.

In-Hospital Consultation Service

You are covered for one consultation during each hospital stay.

To be covered, the examination must meet the following conditions:

- The attending physician must have requested the consulting physician to make the examination in connection with the diagnosed condition;
- The consulting physician's findings and recommendations must be entered on the inpatient's hospital chart;
- After giving the consultation, the consulting physician must not give further services as an attending physician.

Elective Second Surgical Opinion Program

You may request a second opinion after your physician has recommended an elective operation. There is no charge to you for the second opinion consultation, or for any tests or diagnostic surgical procedures necessary to provide the second opinion. If the second opinion consultant recommends against surgery, you may request a third opinion at no cost to you.

Shock Therapy Service

This program provides benefits for shock treatment that induces coma or convulsions. This includes electroshock treatments, insulin shock treatments, and other similar treatments given for a psychiatric condition to an inpatient or outpatient. Payment for this service includes payment for anesthesia in connection with the shock treatment and for all other eligible services performed on that day of the psychiatric condition. Benefits for these connected services may not be claimed separately under other provisions of this program. There is a limit of 12 shock treatments available per benefit year for any eligible person.

Breast Prostheses

The cost for breast prostheses is covered when provided by and billed by a physician following reconstructive breast surgery.

Obstetrical Service

Services for pregnancy or childbirth, or for any related diseases, injuries or

conditions are covered. Care of a healthy newborn child while both mother and child are hospitalized is included in the payment for this service. If the child's care is given by a physician other than the one who gave obstetrical care to the mother, both services are eligible for separate payment.

If a pregnancy ends before it has run 28 weeks, obstetrical service will be covered only if it is given in a hospital. Obstetrical services for an abortion will also be covered as long as the abortion is legal and is performed in a state licensed abortion clinic.

Visits by a physician for complications of pregnancy also are covered for inpatients who are eligible for obstetrical service. These visits are eligible for payment in addition to the delivery services. They are covered as part of the in-hospital medical service described in this booklet.

Obstetrical care is not available to dependent children covered under this program.

Transfusion Service

The administration of exchange and direct transfusions is covered. There is no separate coverage for other transfusions except when they are administered on an outpatient basis.

Outpatient Services

The following services are covered when given to an outpatient if they are medically necessary and performed by a physician:

- Cardiac pacemaker follow-up examination;
- Dialysis treatment;
- Removal of implanted orthopedic hardware;
- Initial treatment of poisoning;
- Cardioversion.

Equivalent "Rider J" Benefits

Under equivalent "Rider J" benefits, we will provide the following services when they are performed and charged by a physician:

- X-ray therapy for a proven malignancy performed outside of a hospital, radioactive isotope therapy (non-sealed sources) wherever performed and chemotherapy performed outside a hospital following surgical procedures in connection with the treatment of breast cancer. Benefits for these services are provided up to a total of $500 per benefit year;

- Pathology, including laboratory examinations, electrocardiograms, electro-encephalograms and other clinical tests we have approved, performed outside of a hospital. Benefits for these services are provided up to a total of $50 per benefit year;
- Diagnostic X-rays performed outside of a hospital and radioactive isotope studies wherever performed. Benefits for these services are provided up to a total of $125 per benefit year;
- Radium, radioactive isotope (sealed sources) or radon therapy performed in an approved hospital as either an inpatient or outpatient. Superficial radium therapy for a proven malignancy will also be eligible even though such services are rendered outside a hospital. Benefits for these services are provided up to a total of $150 per benefit year;
- Physical therapy performed outside a hospital. Benefits for these services are provided up to a total of $50 per benefit year.

These dollar limits are the total amounts that will be paid for each eligible person in any one benefit year by the Plan for Hospital and Medical-Surgical benefits either separately or together, for the same type of services. Also, within each category, there is a specific allowance for each type of service performed.

There are no benefits for any test or service in connection with routine physical examinations or check-ups. In addition, the following are not covered: any procedure involving care of the teeth; research studies; screening; routine tests for hospital admission; fluoroscopy without films; tests related to pregnancy or to check for pregnancy, regardless of the test findings, of a child dependent; any other tests or X-rays that are not performed to specifically diagnose an illness or injury.

Initial Accidental Injury Service

You are covered for medical services for an accidental injury from an external cause. These initial services are covered if they're given within 48 hours after the accident, in either the hospital outpatient department or out-of-hospital, but only for the first visit.

Skilled Nursing Facility Medical Service

Benefits are provided under this program for services in skilled nursing facilities. To be covered, this care must meet the following conditions:

- It must follow at least three days of in-hospital medical (non-surgical) services;
- The patient must be transferred directly from the hospital to the skilled nursing facility;

- The patient must be receiving hospital benefits for skilled nursing facility care.

When these conditions are met, the patient is entitled to benefits for physician's visits in the skilled nursing facility.

The following benefits are available: during the first week in the skilled nursing facility, one visit by a physician per day is covered. During the second week, one visit by a physician every other day is covered. After the second week, one visit by a physician every third day is covered up to your 30th day of confinement. Post-operative care is not covered in a skilled nursing facility.

It's important to remember that the benefits available for a stay in a skilled nursing facility depend on the number of remaining eligible in-hospital medical days.

Home Medical Service

Care at home under a physician's supervision can sometimes substitute for care in a hospital or skilled nursing facility. When such home care comes immediately after a non-surgical hospital confinement of at least three days or after an eligible stay in a skilled nursing facility, we cover physician's visits for such home care. One visit per week is covered up to a maximum of 16 visits in a 120 day period. These benefits are available only as part of the eligible in-hospital medical visits that began during the hospital confinement.

Home care is available only when the eligible person would otherwise have to stay in hospital or skilled nursing facility. We can require evidence that the home care is necessary and that institutional care would otherwise be needed. Home medical service does not cover any of the following: post-operative care; care for mental, psychoneurotic and personality disorders; or care for tuberculosis.

Plan Payment

Service Benefits

You are covered under our equivalent Performance And Cost Effectiveness ("P.A.C.E.") program. You are eligible to receive "service benefits" for services covered under this program. All services are subject to Usual, Customary and Reasonable charges as determined by I.D.A.

Limits Set By Our Equivalent "P.A.C.E." Allowance

To be eligible for payment, services must be personally performed by a physician. We are not liable to pay more than our equivalent "P.A.C.E." Allowance for any covered service.

When You Are Not Eligible For Service Benefits

If the physician's fee for eligible services are higher than our equivalent "P.A.C.E." Allowance for the services, as determined by us, you will be liable for the difference. If the physician's fee is less than our equivalent "P.A.C.E." Allowance, we won't pay more than the amount of the physician's fee.

How To Submit A Claim

If you require a physician's services for any surgical or medical care covered by the program, show your identification card to him. You are responsible for having your physician complete the claim form. Without the completed claim form, we cannot consider your claim for payment.

Payment is then made according to the allowances scheduled for the covered service you received - surgery, medical care visits in the hospital, or other eligible physician services.

Whom We Will Pay

Payment for services under this program can go to you or directly to the physician who performed the covered service.

If a physician performs a covered service, the amount payable under this program will go to the physician.

We will make payment under this program to you, the subscriber, whenever you pay a physician for a covered service before submitting your claim and the physician certifies this to us. The physician can do this simply by completing a box on the claim form. This is true whether or not you received the service in New Jersey.

Send the completed claim form to Insurance Design Administrators, P.O. Box 875, 3 Post Road, Oakland, New Jersey 07436.

If, for any reason, the claim you submit to us is not eligible, you will be notified of this within 90 days of the receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section this booklet.

Exclusions Under Your Hospital And Medical-Surgical Programs

The following services are not covered under your Hospital and Medical-Surgical programs:

- Any service that does not meet the medical necessity or level of care requirements of this program;
- Services for treatment of any condition, disease, illness or injury that's covered under any Worker's Compensation Law, Occupational Disease Law, or any similar law. This is true regardless of where the law is in effect, regardless of whether the eligible person actually claims compensation or receives benefits under those laws and regardless of whether or not the eligible person has any recovery from a third party for damages resulting from such condition, disease, illness or injury;
- Services provided under any laws or governmental program. This exclusion will apply regardless of where the law is in effect and whether or not you assert your rights to obtain that coverage;
- Services to anyone who is on active military duty;
- Services made necessary by a disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
- Services provided to you for screening, research studies or experimentation, mandatory consultations required by hospital regulations, routine pre-operative consultations, and stand-by services;
- Services that usually are provided without charge to the patient. Even when charges are billed, they are excluded from coverage if they are not usually collected when there is no insurance coverage;
- If you are eligible for Medicare, the benefits of this program are reduced to the extent that benefits for the services received are available under Medicare;
- Services given during a hospital, skilled nursing facility, detoxification or residential facility stay whenever the stay is primarily for physical or rehabilitation therapy;
- Services given during a hospital, skilled nursing facility, detoxification or residential facility stay whenever the stay is primarily for: bed rest, rest cure, convalescent, custodial or sanatorium care, diet therapy or occupational therapy, or any combination of these reasons;
- Any admission or any home care program which began prior to your effective date of coverage or after the date you are no longer eligible for benefits;
- Physician services for anesthesia and consultation when they're given in connection with any other service that is not covered;
- Services involving equipment or facilities used when the purchase, rental or construction has been approved in compliance with applicable state laws or regulations;
- Personal comfort and convenience items;
- Claims not submitted within one year from the date of termination of eligible care
- Charges incurred during your temporary absence from the eligible provider's grounds before your discharge;
- Skilled nursing facility services for care of mental, psychoneurotic or personality disorders;
- Home care visits for care of mental, psychoneurotic, or personality disorders

or tuberculosis or in connection with administration of dialysis; housekeeping services under home care visits;

- Hospital services or supplies in connection with inpatient radiation therapy;
- X-ray therapy, radium therapy, radon, or radioactive isotope therapy (except as provided for under equivalent "Rider J" benefits);
- Blood, plasma, other blood derivatives or components when used as blood substitutes or replacements;
- Orthopedic or prosthetic devices such as, but not limited to, heart valves, artificial limbs and the like. However, cardiac pacemakers and breast prostheses are eligible;
- Transportation services;
- Private nursing;
- Except for the coverage specified under dental surgical service, dental surgery is excluded. Physician charges for dental services involving prostheses, orthodontia, operative restorations, fillings, medical or surgical treatment of caries, gingivitis, or radicular or dentigerous cysts are all excluded. Tooth extraction is excluded unless there is bony impaction of the tooth. These services are all excluded regardless of where they're required because of an accidental injury;
- Removal of abnormal skin outgrowths and other growths, unless the services involve cutting through all layers of the skin;
- Services performed by surgical assistants not employed by a hospital;
- Services performed before your effective date of coverage and services given after the date you no longer are eligible for benefits;
- Skin, organs or other tissue for grafting or transplants, and physician's services given to the donor;
- Services intended to improve or change appearance, except for services required to correct defects resulting from disease, trauma, birth, developmental anomalies or previous therapeutic processes;
- Organ transplant procedures other than kidney, cornea, heart valve and certain bone marrow transplants, even if the transplant procedure becomes accepted medical practice and is no longer considered experimental;
- Allergy testing;
- Eye refractions and hearing surveys;
- Any physician services which are not specifically covered under this program;
- Services and supplies for any condition related to the pregnancy of a child dependent; routine care of a healthy newborn infant;
- X-rays, radon, radioactive isotopes and other radioactive substances, and non-surgical services related to the use of these radioactive substances for diagnosis or therapy as a Medical-Surgical benefit;
- Making or interpreting x-rays, fluoroscopic examinations, electrocardiograms, electroencyphalograms, photomotograms and other graphic studies as a Medical-Surgical benefit.

- HOSPICE CARE BENEFITS WILL NOT BE PROVIDED FOR:
  - Medical care rendered by the patient's private physician;
  - Volunteer services;
  - Pastoral services;
  - Homemaker services;
  - Food or Home-delivered meals;
  - Non-authorized private-duty nursing services;
  - Dialysis treatment;
  - Bereavement counseling;

Major Medical Benefits

Your Major Medical Benefits

Your Major Medical program protects you against the extensive medical expenses which can result from a major illness or injury. It supplements your basic IDA program so that you and your dependents have the extra protection needed for especially serious, lengthy, and costly sicknesses or accidents.

How The Major Medical Program Works

After excluding all of the benefits which are eligible under the "basic" Hospital and Medical-Surgical contract issued to your group, the first $200 of reasonable and customary charges for the items shown under covered medical expenses is paid by you. This $200 is called the deductible.

A deductible applies once to each eligible person in a benefit period. However, the total deductible for a family in any one benefit period will not be more than $400. The family deductible can be satisfied by any combination of expenses from either all or some of the family members, except that no individual can contribute more than the individual deductible amount. If one family member meets the individual deductible, this program will pay for that person's additional covered medical expenses even if the deductible for the entire family has not been met.

When two or more eligible family members are injured in the same accident, only one deductible per benefit period will be applied to all covered medical expenses resulting from that accident.

Any covered medical expenses incurred during the last three calendar months of any benefit period which were applied against the deductible for that benefit period may be carried over and also applied against the deductible for the next benefit period.

If you were insured under another Major Medical program of your current group on the day before your coverage under this program began, any charges for covered medical expenses which were applied to the other program's Major Medical deductible for the final benefit period in effect under the prior program may be applied toward satisfaction of this program's deductible for the initial benefit period.

Benefit Period

The benefit period is from January 1 to December 31 in each year while the coverage remains in effect.

Your Coinsurance

After you have paid your deductible, you share in paying a part of the balance of covered medical expenses. This is called your coinsurance. After basic Hospital and Medical-Surgical benefits have been provided and the deductible has been met, the Major Medical program will pay 80% of the first $2,000 of covered medical expenses for each eligible person, and then increase payment to 100% of covered medical expenses for the rest of that benefit period. This means that we will pay $1,600 and you will be responsible for $400 out-of-pocket in addition to the deductible, before Major Medical payment increases to 100% of covered medical expenses.

When two people under the same family have reached the 100% level during the same benefit period, the remaining family members will receive 100% of covered medical expenses for the rest of that benefit period.

However, this provision does not apply to covered medical expenses for outpatient and out-of-hospital mental care.

Maximum Benefits

While coverage is in effect, each eligible person is entitled to $1,000,000 to be paid for Major Medical expenses incurred during a benefit period and $1,000,000 to be paid for Major Medical expenses incurred during his or her lifetime for all covered medical expenses.

Payment for mental care is limited to $10,000 per benefit period and $20,000 per lifetime for each eligible person.

Reinstatement Of Benefits

Each year on January 1st, each eligible person who then has benefits from the

previous benefit period charged against the lifetime maximum, will have the lesser of payments made or $2,000 restored automatically for future use.

If $1,000 or more in benefits is paid under this program, you can have the lifetime maximum fully reinstated by furnishing satisfactory evidence of insurability to us at your expense. You can get the evidence of insurability form from us. The information will be reviewed by us and you will be advised of our decision, including the date for the reinstatement of the lifetime maximum.

Covered Medical Expenses

Covered medical expenses are the reasonable and customary charges as determined by us for the following services and supplies when they are performed or prescribed by a physician and are medically necessary for the diagnosis or treatment of an illness or injury:

- Services of a physician (charges by a physician in excess of the equivalent "P.A.C.E." allowance for the particular service will NOT be considered a covered medical expense);
- Room and board, including special diets and general nursing service in a hospital, but not to exceed, for each day a private room is used, the hospital's average daily semi-private room rate;
- Use of operating, recovery, treatment, delivery and emergency room equipment and facilities;
- Expenses incurred in either an intensive care unit or cardiac care unit or a hospital;
- Medical and surgical dressings, supplies, casts and splints;
- Anesthetics and their administration;
- Diagnostic X-ray and laboratory services;
- Radiation therapy, including administration, materials and supplies, and use of equipment; chemotherapy;
- Oxygen and its administration;
- Physical and rehabilitation therapy;
- Speech therapy services billed for by a hospital or physician, or prescribed by a physician and rendered by a registered speech therapist, to restore speech loss or to correct an impairment due to a congenital defect for which corrective surgery has been performed, or for an accident or a sickness other than a functional nervous disorder;
- Blood transfusions, including cost of blood, blood plasma and blood plasma expanders, when it is not donated or replaced through a blood bank or otherwise;
- Drugs, medicines and dressings used in a hospital or health care facility; Experimental drugs and contraceptives are not eligible;
- Services of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) while

the patient is in the hospital, and the services of a registered nurse outside the hospital. Charges for the services of a private duty nurse who is an immediate relative or member of the patient's household will be covered for an 8-hour shift in each continuous 24-hour period only if satisfactory proof is furnished that he or she otherwise would have been gainfully employed as a nurse;

- Rental of a wheelchair, hospital bed, oxygen tent or other durable medical equipment required for therapeutic use, or purchase of such equipment if the cost would be less than the rental;
- Prosthetic appliances necessary to alleviate or correct conditions arising out of accidental injury occurring or illness beginning after your effective date under this program;
- Breast prostheses following eligible reconstructive breast surgery;
- Treatment of diseases and injuries of the eye; special eyeglasses and contact lenses which replace the human lenses as a result of intra-ocular surgery or congenital disease (replacement of these contact or eyeglass lenses will be covered when a change in prescription is necessary). The lenses specified in this paragraph will be covered only when they become necessary for the correction of conditions arising out of injury or illness occurring while the eligible person is covered under this program;
- Eligible outpatient surgical services performed at a surgical center;
- Services provided by a detoxification or residential facility for the treatment of alcoholism consisting of:
  - Bed and board in a semi-private room;
  - General nursing services;
  - Services of the staff (voluntary or paid employees of the facility) including necessary trained professionals contracted or paid for by the facility;
  - Biologicals, solutions, drugs, medicines and medications used while the patient is in the facility and which, at the time prescribed, are in commercial production and commercially available to the facility;
  - Laboratory tests necessary for patient care (but not X-rays);
  - Psychological testing by a licensed psychologist;
  - Individual and group therapy or counseling;
  - Family counseling;
  - Occupational therapy (but not diversional or recreational therapy or activity).

Rehabilitation services on an ambulatory basis, prescribed by a licensed physician, and provided under a program approved by the New Jersey State Division of Alcoholism (or in other states, as approved by the state), will be covered when provided as outpatient services by an approved hospital or residential facility or as aftercare by a detoxification facility. The eligible rehabilitation services are:

- Services of staff, including necessary trained professionals;
- Individual and group therapy or counseling;
- Family counseling;
- Initial diagnostic evaluation in the outpatient department or clinic of a hospital.

You are entitled to benefits for your physician's inpatient medical visits for acute care and treatment of alcoholism during a covered hospital admission;

- Professional ambulance service (surface transportation only) used locally to or from the hospital except in connection with outpatient care of non-accidental illness;
- Dental care and treatments, dental surgery or dental appliances only if such charges are made necessary by accidental bodily injury occurring while the eligible person is enrolled under this program; extraction of bony impacted teeth, dental surgical services recognized as common to both the medical and dental professions such as treatment of malignancy of the mouth;
- Physician services for any obstetrical condition including childbirth, abortion or miscarriage, for an enrolled employee or enrolled spouse of an employee. **Child dependents are not eligible for obstetrical care;**
- Benefits for outpatient and out-of-hospital mental care include the expenses described under this section when received in the outpatient department of a hospital or outside a hospital. Benefits also include the services and supplies of approved day-care and night-care treatment centers; psychotherapeutic services such as individual counseling, family counseling, group therapy, and electroshock therapy rendered by a physician or a mental health team (physician, and one or more of the following - psychiatric nurse and psychiatric social worker).

  We will pay 80% of covered medical expenses (physician's visits, day-care and night-care, prescription drugs, etc.) in excess of the deductible for outpatient and out-of-hospital mental care.

How To Claim Benefits

When To Submit A Claim

When eligible expenses not covered by your basic Hospital or Medical-Surgical program exceed your deductible within your benefit period, you may file a claim.

Itemized Bills

Itemized bills are necessary to process a claim. Obtain your itemized bills from the providers of services for all covered medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Name of patient;
- Date of service;
- Type of service;
- Charge for each service.

Bills for services of private duty nurses must show that the nurse is a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) and must include his or her license number. Along with the bill, you must submit a letter from the attending physician certifying that the services of the nurse were medically necessary and not provided as a convenience for you or for your family.

If payment has been made by another carrier or Medicare for any of the expenses being submitted to us, you must include the original copy of the explanation of benefits from the carrier or Medicare along with the itemized bills and receipts.

Completing The Claim Form

Be sure to fill out the claim form completely. Include your identification number and your group name. These appear on your identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

Submitting A Major Medical Claim

The claim you submit for Major Medical benefits is handled differently than your basic Hospital and Medical-Surgical benefits. All benefit payments under your Major Medical program will be made directly to you. You will be reimbursed for eligible expenses upon receipt of your properly completed and substantiated claim.

When either you or your physician or other provider of services sends a claim to us and some or all of these services or charges are not covered under your basic Medical-Surgical program, the Major Medical Claims Department will be notified automatically and process the balance. A message to this effect will appear on your Explanation of Benefits. If there is no message, you must file a Major Medical claim. If your physician or provider has not been paid by you, the Major Medical payment will be sent directly to the physician or provider. You will be advised of this by a message on your Major Medical Explanation of Benefits form, or if you

have not satisfied your deductible, you will be advised of the amount credited toward it.

Submitting Your Claim

Send each completed claim form together with all applicable itemized bills and receipts to the address shown on the claim form. Once you have satisfied your deductible and have submitted your first claim, all other claims for covered medical expenses should be sent to the address shown on the claim form. Claims for Major Medical benefits must be submitted no later than December 31 of the calendar year following the year in which expenses were incurred.

If, for any reason, the claim you submit to us is not eligible, you will be notified within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section of the booklet.

Exclusions Under The Major Medical Program

These following services are not covered under your Major Medical program:

- Any service that does not meet the medical necessity or level of care requirements of this program;
- Service for any sickness, disease or injury occurring during military service;
- Disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
- Service for any sickness, disease or injury arising out of or in the course of employment and for which benefits and/or compensation are wholly or partially available under any Worker's Compensation, occupational disease, unemployment, temporary disability benefits or compensation law or similar legislation whether or not the person asserts his or her rights under such legislation and whether or not there are recoveries against third parties for damages;
- Services and/or supplies furnished under the laws of the United States, of any State, of any foreign country or of any subdivision or agency of any of the foregoing;
- Services or supplies for cosmetic purposes except for the correction of defects incurred through traumatic injuries sustained by you while covered under this program;
- Services received before the effective date of coverage under this program;
- Services or supplies in connection with any procedure or examination not incident to, or necessary for, diagnosis of any injury or sickness for which bonafide provisional diagnosis has been made because of existing symptoms;
- Travel, whether or not recommended by a physician;

- Services or supplies not specifically listed in this booklet as covered medical expenses;
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the eligible person enrolled, applied or maintained eligibility for such benefits under Medicare. If you are eligible for Medicare, the benefits of this program are reduced to the extent that benefits for the services are available under Medicare;
- Convalescent, custodial or sanitorium care or rest cures;
- Durable medical equipment which is primarily for comfort or convenience rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, heating pads and similar supplies which are useful to a person in the absence of illness of injury;
- Services rendered for screening, research studies or experimentation;
- Services for which no charge usually would be made to the patient, or if made, usually would not be collected if no health benefits coverage existed;
- Diversional/recreational therapy or activity;
- Services of a licensed practical nurse (L.P.N.) outside a hospital;
- Services and supplies listed as covered medical expenses to the extent they are covered under your group's basic Hospital and Medical-Surgical contract or could have been covered benefits if the provisions governing obtaining care under the basic contract had been complied with. This exclusion will apply whether or not the patient is in fact enrolled under the basic Hospital and Medical-Surgical contract and whether or not claim is made for the basic benefits;
- Any deductible or copayment applicable to Hospital benefits provided under basic coverage;
- Any balances remaining due to reduced Hospital payments under the Pre-Admission Review program;
- Dental care, dental surgery or dental appliances except as specified under the covered medical expenses section of this booklet;
- Organ transplant procedures other than kidney, cornea, heart valve and certain bone marrow transplants, even if the transplant procedure becomes accepted medical practice and is no longer considered experimental;
- Prescription Drugs purchased from a pharmacy. However, the Prescription Drug Copayment is eligible for payment;
- Hearing aids or eyeglasses or examinations for the prescription or fitting of them except as specified under the covered medical expenses section of this booklet;
- Services for any condition related to the pregnancy of a child dependent; routine care of a healthy newborn infant except as specified under the covered medical expenses section of this booklet;
- Services which are not prescribed or performed by or upon the direction of a physician or eligible provider;

- Services for any condition, including alcoholism treatment, will be provided only for the length of time and at the level of care . . . hospital, detoxification facility, residential facility, ambulatory care . . . medically necessary for the patient's condition. The non-availability of other facilities will not be considered a valid reason for admitting a patient to a higher level of care than is medically required for his condition.

Services For Automobile Related Injuries

Under this program, the Plan will provide secondary coverage to PIP unless the Plan has been elected as primary coverage by or for the Eligible Person covered under this contract. This election is made by the named Insured under the PIP policy and affects that person's family members who are not themselves the named insured under another auto policy. The Plan may be primary for one Eligible Person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Plan is secondary to Other Automobile Insurance Coverage. However, if the Other Automobile Insurance contains provisions which made it secondary or excess to the Plan, then the Plan will be primary.

If there is a dispute as to whether the Plan is primary or secondary, the Plan will pay benefits as it is were primary.

If the Plan is primary to PIP or other Automobile Insurance Coverage, it will pay benefits subject to the terms, conditions and limits set forth in your Contract and only for those services normally covered under your Contract.

If the Plan is one of several health insurance plans which provide benefits for Automobile Related Injuries and the Eligible Person has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If the Plan is secondary to PIP, the actual benefits payable will be the lesser of:

a. the remaining uncovered allowable expenses after PIP has provided coverage after application of co-payments, or

b. the actual benefits that would have been payable had the Plan been providing coverage primary to PIP.

Medicare And Your Benefits

If you are eligible for Medicare, actively working and are age 65 or over; or if your spouse is eligible for Medicare and age 65 or over, while you are actively working; you and/or your spouse have the opportunity to choose either this program or Medicare as your primary health benefits program.

If you choose Medicare, your Hospital, Medical-Surgical and Major Medical benefits will end for you and your eligible dependents.

If you choose this program as your primary coverage, you and your eligible dependents will continue to be eligible for the benefits described in this booklet, and Medicare will supplement these benefits.

Contact your enrollment official for further details about your eligibility for Medicare or Hospital, Medical-Surgical and Major Medical benefits when you reach age 65.

If you are eligible for Medicare, under or over age 65 and not actively working, this coverage will be reduced by any amount that Medicare will pay for those services. If applicable, this reduction will be made whether or not you claim or receive the benefits available under Medicare. If you are in this category, you should contact your enrollment official for further information.

If your employer employs 100 or more and you are under age 65 and are disabled, then the benefits of this program may be primary. If applicable, Medicare will supplement these benefits.

How To File A Medical-Surgical Claim If You Are Eligible For Medicare

Follow the procedure that applies to you from the categories listed below when filing your Medical-Surgical claim.

New Jersey Physicians Or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The physician or provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, you will receive an Explanation of Benefits form from Medicare;

- If the remarks section of the Explanation of Benefits contains the following statement, you need not to take any action. "This information has been forwarded to IDA for their consideration in processing supplementary coverage benefits";
- If the above statement does not appear on the form, you should indicate your identification number and the name and address of the physician or provider in the remarks section and send it to us.

Out-Of-State Physicians Or Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed;
- When you receive the Explanation of Benefits form, indicate in the remarks section your identification number and the name and address of the physician or provider and send the form to us for processing.

Out-Of-Country Physicians Or Providers:

Medicare will provide benefits for services of a physician or provider out of the country under the following instances:

- When an emergency arises while the Medicare recipient is in the United States, and the nearest source of adequate hospital care is in Canada or Mexico;
- If the Medicare recipient resides in the United States, but the nearest source of non-emergency hospital care is in Canada or Mexico;
- When the Medicare recipient is traveling between Alaska and another state and an emergency occurs requiring hospitalization in a Canadian hospital.

If you incur a claim in any of the above circumstances, any Social Security office will help you complete the Request for Medicare Payment. The Request for Payment should then be sent to the Medicare Part B carrier in the area where you reside.

When you receive the Explanation of Benefits form, you should proceed in the same manner as you would if you were submitting a claim to us from a New Jersey physician or provider.

As Medicare provides virtually no benefits for services performed in a foreign country, we will provide full benefits (within the limits of your group's contract) for eligible claims incurred out of the country.

You should pay the person performing the services and then obtain an itemized bill containing the following information:

- The date of service(s);
- The specific service(s) performed;
- The charges;
- Your identification number;
- The patient's name and, if the patient is your dependent, your name and address;
- If the bill is in a foreign language, a brief description in English of the services performed;
- The itemized bill should than be sent to us. We will pay you directly. Any balances over our payment are your responsibility.

Claims Appeal

You or your authorized representative may appeal and request us to reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the limitations and/or exclusions of your program.

This inquiry may be made by either telephoning our Service Center at one of the numbers listed at the back of this booklet or by writing to Insurance Design Administrators, P.O. Box 875, 3 Post Road, Oakland, New Jersey 07436. The following information must be given at the time of each telephone or written inquiry:

- Name(s) and address(es) of patient and subscriber;
- Subscriber's identification number;
- Date(s) of service(s);
- Medical-Surgical claim number (indicated on Subscriber Notification);
- Provider's name . . . for example, hospital, detoxification facility, residential facility, or physician;
- Reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim which was not given to us when the claim was first submitted, be sure to include it.

Upon request, you have the right to review pertinent documents. Copies of your group's contract are available from your employer. A copy of other material relative to your claim will be made available from us. In some cases, written authorization from your attending physician to release certain information will be necessary and you will be informed accordingly.

Inquiries should be made within 12 months of the date you were first notified of the action taken to deny all or part of your claim. Upon receipt of the written inquiry, your claim will be researched and reviewed thoroughly and you will be notified of the decision on your appeal within 60 days of receipt of the appeal.

However, special circumstances, such as delays by you or the provider in submitting necessary information, may require an extension of this 60-day period.

If legal action is brought against us for a claim that has been wholly or partially denied, the action must be brought within 12 months of the first denial, or if the claim has been appealed, within 12 months of the denial of the appeal.

When you need to call us, identify yourself and the group program through which you are enrolled. Also give your identification number. Space is provided to write in names, addresses and phone numbers on the last page of this booklet.

Coordination Of Benefits

Almost all group insurance programs provide for the coordination of benefits. A program without such a provision is automatically the primary program whenever its benefits are duplicated. For programs that do have this provision, the following rules determine which one is the primary program:

- If you are the patient, then this program is the primary program. If your spouse is the patient and covered under a program of his or her own, then that program is the primary program.

- If a dependent child is the patient and is covered under both parents' programs, the following birthday rule will apply:

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday if July 16 and mother's birthday is May 17, the mother's plan would be primary for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary. **Only the month and the day (not the year) of each parent's birthday is used to determine which plan is primary.**

This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

- If two or more programs cover a person as a dependent child of separated or

divorced parents, benefits for the dependent child will be determined in the following order:

- The program of the parent with custody is primary;
- The program of the spouse of the parent with custody of the child;
- The program of the parent not having custody of the child. However, if it has been established by a court decree that one parent has responsibility for the child's health care expenses, then the program of that parent is primary.

The benefits of the program which covers a person as an active employee or his dependents will be determined before the benefits of a program which covers such person as a laid-off or retired employee or his dependent. If the other benefit program does not have this rule and, as a result, do not agree on the order of benefits, this rule will not apply.

- If none of the above rules determine the order of benefits, the program that has covered the patient for the longer period is the primary program.

This program will provide its regular benefits in full when it is the primary plan. As a secondary plan, this program will provide a reduced amount which when added to the benefits under other group plans will equal up to 100% of the charges for the patient's eligible expenses under this program, but in no event will this program's liability as a secondary plan exceed its liability as a primary plan.

If you have any questions about this program, call Insurance Design Administrators.

Telephone personnel are available Monday through Friday from 8:30 a.m. to 4:30 p.m.

For the Hospital, Medical-Surgical and Major Medical programs call:

(201) 337-0555
(800) 225-1345

Always have your identification card handy when calling us. Your ID number helps us get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

_____

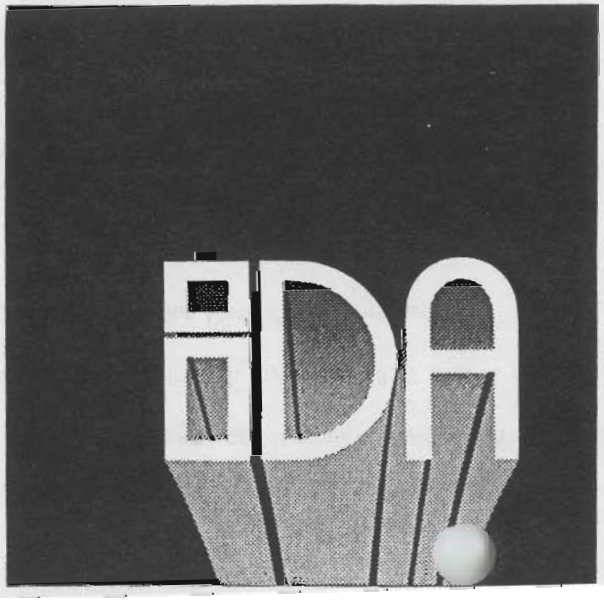
The identification number shown on my identification card:

_____

The effective date when my coverage begins:

_____

PASSAIC COUNTY HEALTH BENEFITS PROGRAM



800-446-9972

3 Post [illegible]d, Oakland, New Jersey 07436 • 201/ 337-0555 • 609/ 344-4840

Wraparound

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SUMMARY PLAN DESCRIPTION

The information furnished herein is designed to acquaint you with the benefits of your Plan which are now available to you and your covered dependents.

GENERAL INFORMATION

Plan Sponsor: County of Passaic
317 Pennsylvania Avenue
Paterson, NJ 07503

Name of Plan: The Plan shall be known as the County of Passaic Employee Health Care Plan.

Plan Administrator: County of Passaic

Address of Plan: 317 Pennsylvania Avenue
Paterson, NJ 07503

Plan Effective Date: October 1, 1992

Plan Fiscal Year Ends: September 30,

Plan Supervisor: Insurance Design Administrators
3 Post Road
Oakland, N.J. 07436
1-(800)-225-1345
(201)-337-0555
(609)-344-4840

Contributions: Non-Contributory

Average Work Week Requirements: 35 hours

Dependent Children's Coverage: Unmarried children are covered until the end of the calendar year in which they attain age 23.

Change Date: First of the month following date of change.

Termination Date: Last day of the month following the date of termination

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the plan benefits (including any limitations and exclusions), the procedures to be followed in presenting claims for benefits, and remedies available for redress of claims denied are in the Plan Document.

Definitions

This section defines certain important words used in this booklet. The meaning of each defined word, whenever it appears in this booklet, is governed by its definition as listed in this section.

We, Us, Our and the Plan. Insurance Design Administrators.

Approved Hospital. A health care facility licensed by the State of New Jersey to provide hospital care and services, or one which meets the same standards if located in another state.

NOTE: Nursing homes; rest homes; health resorts; institutions for the aged; infirmaries; places primarily for domiciliary care, custodial care, drug addiction, pulmonary tuberculosis; or other institutions providing non-medical services are not approved hospitals.

Government Hospital. A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county or city hospital.

Detoxification Facility. A health care facility licensed as a detoxification facility by the State of New Jersey, or one which meets the same standards if located in another state.

Residential Facility. A health care facility licensed, certified or approved for treatment of alcoholism by the State of New Jersey, or one which meets the same standards if located in another state.

Surgical Center. An ambulatory care facility licensed as such by the State of New Jersey to provide same-day surgical services or one which meets the same standards if located in another state.

Approved Hemophilia Treatment Center. A health care facility licensed by the State of New Jersey for the treatment of hemophilia or one which meets the same standards if located in another state.

Skilled Nursing Facility. A health care facility or a designated part of a hospital which provides skilled nursing care and related treatment.

Home Health Care Agency. An agency which provides skilled nursing and other related treatment in a patient's home.

Hospice. A hospice care program which is approved by either the Joint Commission on Accreditation of Hospitals or Medicare.

Physician. A doctor who is licensed to practice medicine and surgery. This includes both doctors of medicine and osteopathy. Physician also includes doctors of dental surgery, doctors of podiatry, doctors of chiropody, bioanalytical laboratory directors, licensed psychologists, certified nurse-midwives, registered physical therapists, physician anesthesiologists and licensed chiropractors.

Certified Registered Nurse Anesthetist (CRNA). A registered nurse, certified to administer anesthesia, who is employed by and is under the supervision of a physician anesthesiologist.

Benefit Month. The monthly period starting with the date shown on your identification card.

Benefit Year. The 12-month period beginning on the date shown on you identification card.

Service Report. The claim form which we need to process a claim for physician's services.

When the term "facility" is used in this booklet it can mean a hospital, detoxification facility, residential facility, surgical center, skilled nursing facility, home health agency or other facility we approve as eligible.

General Information

How to Enroll

You may enroll in the IDA health care program by completing an enrollment form. If you enroll your dependents, their coverage will become effective on the same date as your own. If you don't apply for coverage for yourself or your dependents when you first become eligible, you must wait for a later open enrollment period to enroll.

Your Identification Card

You will receive an IDA identification card to show to the hospital, physician or provider when you need to use your benefits. Your identification card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can start to use your benefits. All of your eligible dependents share your identification number.

Always carry this card and use your identification number when you receive covered services. If you lose your card, you can still use your coverage if you know your identification number. The inside back cover of this booklet has space to record your identification number along with other information you will need when making inquiries about your benefits. You should, however, contact your enrollment official immediately to replace the lost card.

You cannot let anyone not named in your coverage use your card. Nor can you let anyone who is not named in your coverage use your benefits or receive payment for them.

When Benefits Begin

Your benefits begin on the effective date shown on your identification card. However, any eligible person who is in a health care facility when coverage would normally start will not receive Hospital benefits under this program during that stay.

For Equivalent "Wraparound Plus Major Medical" Only
If, at the time coverage under this program would otherwise begin, (1) you are not actively at work for your employer, coverage for you and your dependents will not begin until the first day of the benefit month following your return to work; or (2) a dependent is confined in a hospital, the dependent's coverage will not begin until the day following that dependent's discharge from the hospital.

Types Of Enrollment Available

You may enroll under the following types of coverage:

- Single - provides coverage only for yourself;
- Parent and Child(ren) - provides coverage for you and your eligible children but not your spouse;
- Family - provides coverage for you, your spouse and your eligible children.

Eligible Dependents

Your eligible dependents are your spouse and your unmarried children under age 23. We consider your children dependents if they are your own, your spouse's natural children, your legally adopted children or a child placed in your home for whom you have begun adoption procedures, or children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible.

Although a child born to unmarried parents is eligible to be enrolled as a dependent, the child must reside with you. The residency requirement may be waived if a court decree makes you financially responsible for the child's health care expenses. Also, if the child's last name is different than yours, a birth certificate naming you as parent must also be received by us.

Coverage for a child ends on the last day of the benefit month in which the child marries or the last day of the calendar year in which the child attains age 23, whichever comes first.

In addition, an unmarried handicapped child may remain covered beyond age 23. A handicapped child is one who is incapable of self-sustaining employment because of mental retardation or physical handicap. The child's handicap must have started before he or she became age 23, and the child must depend chiefly on you for support.

For the handicapped child to remain covered, you must give us proof of the child's incapacity within 31 days from the end of the calendar year in which the child becomes 23. The proof must be in a form which meets our approval.

Once we receive acceptable proof of the handicap, that child can remain covered as long as the Family or Parent and Child(ren) contract is in effect and the handicap continues to exist. Coverage will end on the last day of the benefit month in which the child ceases to qualify as a handicapped child.

Change In Type Of Coverage

If you want to change your type of coverage, see your enrollment official. If you marry, you should arrange for enrollment changes within 60 days before or after your marriage.

If you gain or lose a member of your family or whenever someone covered under this program changes family status, you should check this booklet to see if coverage should be changed. This can happen in many ways: for example, through the birth or adoption of a child, or the divorce or death of a spouse.

- If you already are enrolled under Family or Parent and Child(ren) coverage, your newborn infant is automatically included;
- If you have Single coverage, your newborn will be eligible from the date of birth if you apply for Family or Parent and Child(ren) coverage within 31 days of birth;
- If you apply for coverage for your newborn between the 32nd and 90th day after the birth, the coverage will be effective on the first day of the benefit month after the date the application was received.

When Your Coverage Ends

Your coverage ends on the last day of the benefit month in which your enrollment in this program ends.

If your enrollment in this program ends, you may continue Hospital and Medical-Surgical protection. You simply transfer to our direct payment coverage.

However, your benefits will not be continued under direct payment coverage if your group's program with us is replaced by another group insurance program.

For the Equivalent "Wraparound Plus Major Medical" program, there is no conversion opportunity available. You may apply directly to us for direct payment Major Medical coverage. The change will made in accordance with our underwriting rules and regulations in effect at the time of the change.

Coverage for a child ends on the last day of the benefit month in which he or she marries or in the case of an unmarried child, at the end of the calendar year in which he or she reaches the termination age.

When your child marries or is no longer eligible as a dependent, he or she also may transfer to direct payment coverage. The child should take prompt action to

obtain this separate coverage. To assure continued coverage, an application should be sent directly to Insurance Design Administrators, P.O. Box 875, 3 Post Road, Oakland, New Jersey 07436 and received by the Plan within 31 days of the date on which your child's coverage will end.

Benefits After Termination

If you or any of your dependents are receiving covered inpatient care at the time your coverage ends, benefits will be available for eligible services provided during the uninterrupted continuation of that stay, but only to the extent that benefits remain.

Extension Of Coverage Due To Group Termination

If you or any of your dependents are totally disabled on the date your group's coverage under this program ends, Hospital benefits will continue to be available for that person, for treatment directly related to the disability only. However, benefits will not be extended beyond (1) 90 days from the date on which your group's coverage ended, (2) the date the disability ends, or (3) the extent benefits remain when the program ends, whichever comes first.

Equivalent "Wraparound Plus Major Medical" benefits will also continue to be available for covered medical expenses resulting from the sickness or injury that caused the disability during the uninterrupted continuation of the disability. However, benefits will not be extended beyond (1) the date the disability ends, (2) 12 months from the date the group coverage ends, or (3) the extent that benefits remain when the program ends, whichever comes first.

If You Leave Your Group Due To Total Disability

If you can no longer be employed due to a total disability, you can arrange to continue coverage through your group (including coverage for dependents) if:

- You were continuously enrolled under the group program for the three months immediately prior to your loss of employment;
- You notify your employer that you want to continue your group coverage within 31 days of the date your coverage would normally end;
- You continue to pay any premiums required for the coverage by your employer.

However, continued coverage under this program for you and your eligible dependents will end at the first occur of the following:

- Failure by you to make timely payment of any contribution required by your employer. If this happens, coverage will end at the period for which

contributions were made;
- The date you become employed and eligible for benefits under another employer's health plan or, in the case of an eligible dependent, the date the dependent becomes employed and eligible for such benefits;
- The date this program ends.

If you are a totally disabled former employee whose group coverage (including coverage for any eligible dependents) has been continued without interruption in accordance with state law, through the employer's prior health insurance carrier, you will also be eligible for coverage under this program. Such coverage will be continued until the former employee no longer meets the eligibility requirements described above.

Totally disabled means that due to injury or illness, as determined by us:

- You are unable to engage in your regular occupation and are not, in fact, engaged in any employment for wage or profit; or
- Your dependent is unable to engage in the normal activities of a person of like age and sex in good health.

Continuing Protection For Surviving Dependents

Eligible dependents of a deceased subscriber may have coverage continued under this program for at least 180 days after the subscriber's death. See your enrollment official for further details and to arrange to make any required premium payments through the group.

When 180 days of group coverage ends, any eligible dependents may transfer to direct payment coverage.

Extension Of Coverage Due To COBRA

If any of the following events occur, you and your eligible dependents may have the opportunity to continue group health coverage which would otherwise end:

- Termination of employment;
- A reduction of your hours so that you or your dependent(s) no longer meet the eligibility requirements for coverage;
- Your death;
- Your legal separation or divorce;
- Your enrollment in Medicare;
- Your child no longer qualifies as a dependent.

You must pay the required premiums to maintain your coverage. If you and/or your

eligible dependent(s) elect to continue coverage, it would be identical to the health care coverage for your group and would be extended as follows:

- Up to 18 months in the event of the termination of your employment or a reduction in your hours such that you no longer meet the eligibility requirements of your group's program;
- Effective December 19, 1989, up to 29 months for qualified beneficiaries Social Security determines were disabled at the time of employment termination or reduction in hours;
- Up to 36 months for your dependent(s) in the event of your death, your legal separation or divorce, if you become enrolled in Medicare or if your child no longer qualifies as a dependent.

You and your dependents also have the option to transfer to direct payment Hospital and Medical-Surgical coverage at the end of this extended period of coverage. For the equivalent "Wraparound Plus Major Medical" program there is no conversion opportunity available. You may apply directly to us for direct payment Major Medical coverage. This change will be made in accordance with our underwriting rules and regulations in effect at the time of the change. See your enrollment official for details on eligibility.

Medical Necessity

We will make payment for benefits under this program only when:

- Services are performed or prescribed by your attending physician;
- Services, in our judgment, are provided at the proper level of care (inpatient, outpatient or out-of-hospital);
- Services or supplies are medically necessary for the treatment and diagnosis of an illness or injury.

THE FACT THAT YOUR ATTENDING PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY FOR THE TREATMENT AND DIAGNOSIS OF AN ILLNESS OR INJURY OR MAKE IT AN ELIGIBLE MEDICAL EXPENSE.

Cost Containment Program

If we determine that an eligible service can be provided in a medically acceptable, cost-effective alternative setting, we reserve the right to provide benefits for such service when performed in that setting.

Human Organ Transplant Services

Benefits are available for services in connection with heart, heart-lung, pancreas and liver human organ transplants.

Benefits also are provided for the surgical, storage and transportation services provided which are directly related to the donation of the organ and billed for by the facility.

The facility where you are being admitted must prenotify IDA of your transplant procedure.

Individual Case Management Program

When it appears that you or your eligible dependent will require long-term or extensive care, you or your physician should contact Insurance Design Administrators at (201) 337-0555 or (800) 225-1345.

Individual Case Management is an additional service offered to help subscribers and their physicians plan for a serious illness or disability.

Hospital Benefits

The following section describes the Hospital benefits available under this program.

Hospital Inpatient Care

You are covered for benefits for the following inpatient hospital services when they are consistent with the diagnosis and treatment of an illness or injury:

- Bed and meals, including special dietary service in a semi-private room;
- General nursing service in all facilities of the hospital;
- Services of all hospital employees, interns, residents, technicians and independent contractors when paid by the hospital for providing covered services;
- Use of operating, treatment, delivery and emergency room equipment and facilities;
- Therapeutic solutions, all types of anesthetic agents, oxygen, sera when used as other than blood substitutes or replacements, dressings, bandages, casts and surgically implanted cardiac pacemakers, including batteries, electrodes and their replacements;

- All drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
- Physical therapy;
- Diagnostic X-ray examinations, radioactive isotope studies, laboratory and pathology services;
- Diagnostic studies in connection with Second Opinion Consultations provided under a contract with us. If we decide that the diagnostic studies in connection with Second Opinion Consultations could have been performed safely and effectively on an outpatient basis, benefits will be limited to what we would have paid if you were an outpatient;
- Blood processing services provided by the hospital or by a non-profit blood supplier for drawing, processing and distributing blood (the cost of blood is not covered);
- Benefits for the cost of breast prostheses in connection with reconstructive breast surgery;
- All other approved hospital facilities and equipment not specifically excluded in this booklet.

Obstetrical Care

We will provide benefits for covered hospital services related to obstetrical care.

Hospital care provided to your newborn child during the initial eligible joint hospital stay of you and your child is covered in your obstetrical care benefits.

Your newborn child will receive separate benefits when the child is enrolled under your type of coverage and is admitted for the treatment of an illness or injury.

Obstetrical care is not available to dependent children under this program.

Private Rooms

If you occupy a private room in a hospital, you must pay the difference between the private room rate and the average room rate for all semi-private rooms in the same area of service of the hospital.

Pre-Admission Testing (PAT)

Diagnostic tests which are eligible under your coverage on an inpatient basis also are covered on an outpatient basis before your admission to a hospital. If PAT is available, it is eligible when you are admitted to a hospital prior to an inpatient hospital stay or prior to ambulatory same-day surgery.

Your doctor decides whether to use PAT. It is covered only if you are scheduled for admission to the hospital for treatment of the diagnosed condition which made the test necessary. However, if your admission does not take place, the testing may still be covered, but only if the admission is postponed or cancelled for at least one of the following reasons:

- The tests show a condition requiring medical treatment before the admission;
- You develop a medical condition that delays the admission;
- A hospital bed is not available on the scheduled date of admission;
- PAT indicates that, contrary to your attending physician's expectation, the admission is not necessary.

PAT benefits are not charged against your equivalent "Rider J" maximums.

Hospital Outpatient Care

This program provides coverage of the same hospital services for outpatients that are eligible for hospital inpatients with the exception of bed and board. Physical therapy and radiation therapy are covered only as shown under the equivalent "Rider J" Benefits.

If you use a hospital outpatient department, benefits are provided for the following situations:

- Hospital care required because of an accidental injury;
- Surgery of a cutting or cauterizing nature other than chemical cauterization. Procedures related to obstetrical care are covered only if you are eligible for obstetrical care;
- Surgical diagnostic procedures which we determine must be performed in the outpatient department instead of out-of-hospital (Note: Contact us if you want to know whether a specific surgical diagnosis procedure is an eligible outpatient service);
- Diagnostic studies in connection with Second Opinion Consultations provided by us;
- Blood transfusions;
- Application and removal of casts;
- Complete cardiac pacemaker follow-up examinations, but not telephone check-ups;
- Dialysis treatment;
- Removal of implanted orthopedic hardware (nails, screws, plates, etc.);
- Treatment of poisoning;
- Rehabilitation services for treatment of alcoholism under a program approved by the New Jersey Division of Alcoholism or, if the hospital is outside of New

Jersey, under a program which meets Joint Commission on Accreditation of Hospitals' standards. Services are limited to an initial diagnostic evaluation, services of individual and group therapy or individual and family counseling.

Equivalent "Rider J" Benefits

Under "Rider J", we will provide benefits for the following additional outpatient hospital services when they are ordered by your physician and performed by a hospital employee.

- X-ray therapy for a proven malignancy, radioactive isotope therapy (non-sealed sources) and chemotherapy following surgical procedures in connection with the treatment of breast cancer. Benefits for these services are provided up to a total of $500 per benefit year;
- Pathology, including laboratory examinations, electrocardiograms, electroencephalograms and other clinical tests approved by us. Benefits for these services are provided up to a total of $50 per benefit year;
- Diagnostic X-rays and radioactive isotope studies. Benefits for these services are provided up to a total of $125 per benefit year;
- Radium, radioactive isotope (sealed sources) or radon therapy. Benefits for these services are provided up to a total of $150 per benefit year;
- Physical therapy. Benefits for these services are provided up to a total of $50 per benefit year.

These dollar limits are the total amount that will be paid for each eligible person in any one benefit year by us for Hospital and Medical-Surgical benefits, either separately or together, for the same type of services. Also, within each category, there is a specific allowance for each type of service performed.

There are no benefits for any test or service in connection with routine physical examinations or check-ups. In addition, the following are not covered: any procedure involving care of the teeth; research studies; screening; routine tests for hospital admission; fluoroscopy without films; tests related to pregnancy or to check for pregnancy, regardless of the test findings, of a child dependent; and any other tests or X-rays that are not performed to specifically diagnose an illness or injury.

Home Dialysis Benefits

We will provide benefits for home dialysis when the home dialysis services are provided by and billed for by a hospital, freestanding dialysis center or home health care agency. The facility must make arrangements for training, equipment, rental and supplies on behalf of the patient. We will pay for these services on a per treatment basis.

Each dialysis treatment will be counted as one benefit day. Benefits will *not* be paid for home nursing services in connection with administration of dialysis.

Home Hemophilia Benefits

The following services are provided for home treatment of routine bleeding episodes associated with hemophilia when provided under the supervision of a state-approved hemophilia treatment center:

- Training for self-administration of home treatment;
- Blood products when used as other than blood substitutes or replacements;
- Blood infusion equipment (syringes and needles).

Benefits In Facilities Other Than Hospitals

Surgical Center Benefits

If you have surgical services performed at a surgical center, benefits will be provided for the use of the facility, if the services are considered eligible outpatient hospital services under this program. Procedures related to obstetrical care are covered only if you are eligible for obstetrical benefits.

You must be admitted and discharged within a 24-hour period.

Detoxification And Residential Facility Benefits

Inpatient benefits. We will provide benefits for the following covered inpatient services for the treatment of alcoholism in detoxification and residential facilities:

- Bed and meals in a standard room. If you occupy a special room in a facility that contracts with us, you must pay any additional room charge for the special room;
- All drugs and medicines used during your hospitalization which are approved by the Food and Drug Administration for use by the general public and are for FDA-approved uses (experimental drugs are not eligible);
- Laboratory tests, but not X-rays;
- Psychological testing;
- Individual and group therapy and individual counseling;
- Counseling for the family of the person who is receiving covered inpatient services;
- Occupational therapy, but not diversional or recreational therapy or activity;
- Services of employees of the facility.

Ambulatory (outpatient) benefits. We will provide benefits when you receive alcoholism rehabilitation services on an ambulatory basis in a residential facility or as aftercare in a detoxification facility. Benefits are provided for the following services:

- Individual and group therapy and individual counseling;
- Counseling for the family of the person who is receiving eligible ambulatory services;
- Services of staff including the necessary trained professionals.

Skilled Nursing Facility Benefits

You may be transferred to a skilled nursing facility immediately following a covered hospital stay of at least 3 days. The services you receive must be consistent with the diagnosis and treatment of the condition which required your covered inpatient stay. All of your prior stay in the hospital must have been eligible for benefits.

You must be transferred to a skilled nursing facility on the same day you are discharged from the hospital.

Skilled nursing facility services include:

- Semi-private accommodations;
- Up to 30 days are available during each admission;
- The same covered services that are available to hospital patients as described in this booklet, but only if they are available at the skilled nursing facility.

Home Health Care Agency Benefits

You may receive services provided by a home health care agency under the following circumstances:

- You must be homebound;
- You must require skilled nursing care, physical therapy or speech therapy under a plan prescribed by an attending physician and approved by us;
- The services you receive must be consistent with the diagnosis and treatment of the condition which required you to have your eligible inpatient stay of at least 3 days;
- When you transfer to home care services following discharge from a hospital stay or discharge from a skilled nursing facility, all of your prior stay in the hospital or skilled nursing facility must have been eligible for benefits. Also, your home care plan must have been established by your attending physician before your discharge.

Home health care agency services include:

- Part-time skilled nursing service provided by or under the supervision of a registered nurse;
- Physical therapy;
- Speech therapy;
- Any other related treatment and services eligible for hospital outpatient benefits except drugs and administration of dialysis;
- Medical social services or part-time services by a home health aide during the period when you are receiving skilled nursing care, physical therapy or speech therapy;
- Up to 60 visits are available in the 120 days following hospital discharge.

Hospice Care

The care must be provided according to a physician-prescribed course of treatment approved by us for an eligible person with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

A hospice care program is a health care program which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

The following services are eligible under this hospice care program:

- Part-time nursing services of an R.N. or L.P.N.;
- Home health aide services provided under the supervision of an R.N.;
- Medical care rendered by a hospice care program physician;
- Therapy services (including speech, physical and occupational therapies);
- Diagnostic services;
- Medical and surgical supplies (with prior authorization) and durable medical equipment;
- Prescribed drugs;
- Oxygen and its administration;
- Respite care;
- Inpatient acute care for related conditions;
- Medical social services;

- Psychological support services to the terminally ill patient;
- Family counseling related to the eligible person's terminal condition;
- Dietician services;
- Inpatient room, board and general nursing services for related conditions;

Respite care benefits are limited to a maximum of ten (10) days.

Hospice care benefits are not limited to or counted against the benefit days available under the eligible person's basic hospital services.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients.

Payment will be 100% of the provider's reasonable and customary charge up to a $10,000 dollar maximum.

Claim And Payment Information

Payment For Hospital Benefits

The following payment provisions apply to hospital, surgical center, detoxification facility or residential facility charges:

- For inpatient and outpatient services covered under this program, our payment to the facility will be payment in full.
- For part benefit days for inpatient or outpatient services covered under this program, we will pay up to $5 per day toward the facility's reasonable charges.

We will pay hospitals operated by the United States government only if:

- Services are for treatment on an emergency basis for accidental injury from external cause;
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Whom We Will Pay

Hospitals will submit your claim directly to us. After approval of your claim, we will pay the hospital.

If you pay a facility for services covered under this program, reimbursement may be made directly to you for the amount we would be required to pay the provider.

Send the itemized bill to Insurance Design Administrators, P.O. Box 875, Oakland, New Jersey 07436.

If, for any reason, the claim you submit to us is not eligible, you will be notified of this within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section of this booklet.

Benefit Days Available

We will pay for eligible care, up to the number of days listed below, but only to the extent we determine such care is medically necessary.

Benefit Days

For inpatient care for general conditions:

- 120 full benefit days;
- Every two days in a skilled nursing facility or every three home care visits will count as one benefit day for inpatient care;
- 245 part benefit days after full benefit days have been used unless the admission is for any of the conditions described below.

For inpatient care of special conditions:

- 20 benefit days for any one or more of the following conditions and their after-effects: tuberculosis, contagious diseases, mental, psychoneurotic and personality disorders;
- These days are eligible only as part of the benefit days available to you for general conditions.

For inpatient care in governmental hospitals:

- 20 benefit days in the following governmental hospitals: hospitals located outside of New Jersey. This does not apply to retired Military Personnel;
- These days are eligible only as part of the benefit days available to you for general conditions.

Your outpatient days are part of your available inpatient days. Each day of outpatient care reduces by one day your available inpatient days.

Renewal of Benefit Days

Benefit days will be renewed on the date your new benefit year starts, provided that, for related conditions, 90 days or more have passed from the date on which inpatient or home care services were last received from an eligible provider.

If you are in a facility or receiving home health care agency services at the time your benefit days would renew, you will be covered only for the unused number of days from the benefit year in effect when the admission occurred.

Exclusions Under Your Hospital Program

Thte following services are not covered under your Hospital program:

- Any service that does not meet the medical necessity or level of care requirements of this program;
- Services for treatment of any condition, disease, illness or injury that's covered under any Worker's Compensation Law, Occupational Disease Law, or any similar law. This is true regardless of where the law is in effect, regardless of whether the eligible person actually claims compensation or receives benefits under those laws and regardless of whether or not the eligible person has any recovery from a third party for damages resulting from such condition, disease, illness or injury;
- Services provided under any law or governmental program. This exclusion will apply regardless of where the law is in effect and whether or not you assert your rights to obtain that coverage;
- Services to anyone who is on active military duty;
- Services made necessary by a disease contracted or injuries sustained as a result or war, declared or undeclared, or any act of war;
- Services provided to you for screening or research studies or experimental procedures, treatments, facilities, equipment, drugs, devices or supplies;
- Any admission or any home care program which began prior to your effective date of coverage or after the date you are no longer eligible for benefits;
- Services of a physician if the physician bills you directly for performing these services regardless of the existence of any financial or contractual arrangement between the physician and the provider;
- Services that usually are provided without charge to the patient. Even when charges are billed, they are excluded from coverage if they are not usually collected when there is no insurance coverage.
- If you are eligible for Medicare, the benefits of this program are reduced to the extent that benefits for the services received are available under Medicare.

- Services given during a hospital, skilled nursing, detoxification or residential facility stay whenever the stay is primarily for physical or rehabilitation therapy;
- Services given during a hospital, skilled nursing, detoxification or residential facility stay whenever the stay is primarily for: bed rest, rest cure, convalescent, custodial or sanatorium care, diet therapy or occupational therapy, or any combination of these reasons;
- Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations;
- Personal comfort and convenience items;
- Services intended to improve or change appearances, except for services required to correct defects resulting from disease, trauma, birth, developmental anomalies or previous therapeutic processes;
- Claims not submitted within one year from the date of termination of eligible care;
- Charges incurred during your temporary absence from the eligible provider's grounds before your discharge;
- Skilled nursing facility services for care of mental, psychoneurotic or personality disorders;
- Home health care visits for care of mental, psychoneurotic, or personality disorders or tuberculosis or in connection with administration of dialysis; housekeeping services under home care visits;
- Blood, plasma, other blood derivatives or components when used as blood substitutes or replacements;
- Orthopedic or prosthetic devices such as, but not limited to, heart valves, artificial limbs and the like. However, cardiac pacemakers and breast prostheses are eligible;
- Private nursing;
- Services performed before your effective date of coverage and services given after the date you no longer are eligible for benefits;
- Transportation services;
- Organ transplant procedures other than kidney, cornea, heart valve and certain bone marrow transplants, even if the transplant procedure becomes accepted medical practice and is no longer considered experimental;
- Hospital services or supplies in connection with inpatient radiation therapy;
- Outpatient and inpatient X-ray therapy, radium therapy, radon, or radioactive isotope therapy (except as provided for under equivalent "Rider J" benefits);
- Services and supplies for any condition related to the pregnancy of a child dependent;
- Routine care of a healthy newborn infant;

- HOSPICE CARE BENEFITS WILL NOT BE PROVIDED FOR:
  - Medical care rendered by the patient's private physician;
  - Volunteer services;

- Pastoral services;
- Homemaker services;
- Food or home-delivered meals;
- Non-authorized private-duty nursing services;
- Dialysis treatment;
- Bereavement counseling.

Equivalent "Wraparound Plus Major Medical" Benefits

Your Equivalent "Wraparound Plus Major Medical" Benefits

Your Equivalent "Wraparound Plus Major Medical" program protects you against the extensive medical expenses which can result from a major illness or injury. Equivalent "Wraparound Plus Major Medical" is one inclusive program which combines basic Medical-Surgical coverage with our traditional Major Medical benefits. This program supplements basic Hospital benefits, providing you and your dependents with the extra protection needed for especially serious, lengthy and costly sicknesses or accidents.

How The Equivalent "Wraparound Plus Major Medical" Program Works

After excluding all of the benefits which are eligible under the "basic" Hospital contract issued to your group, the first $200 of reasonable and customary charges for the items shown under covered medical expenses is paid by you. This $200 is called the deductible.

A deductible applies once to each eligible person in a benefit period. However, the total deductible for a family in any one benefit period will not be more than $400. The family deductible can be satisfied by any combination of expenses from either all or some of the family members, except that no individual can contribute more than the individual deductible amount. If one family member meets the individual deductible, this program will pay for that person's additional covered medical expenses even if the deductible for the entire family has not been met.

When two or more eligible family members are injured in the same accident, only one deductible per benefit period will be applied to all covered medical expenses resulting from that accident.

Any covered medical expenses incurred during the last three calendar months of any benefit period which were applied against the deductible for that benefit period may be carried over and also applied against the deductible for the next benefit period.

If you were insured under another Major Medical program of your current group on the day before your coverage under this program began, any charges for covered medical expenses which were applied to the other program's Major Medical deductible for the final benefit period in effect under the prior program may be applied toward satisfaction of this program's deductible for the initial benefit period.

Benefit Period

The benefit period is from January 1 to December 31 in each year while the coverage remains in effect.

Your Coinsurance

After you have paid your deductible, you share in paying a part of the balance of covered medical expenses. This is called your coinsurance. After basic Hospital benefits have been provided and the deductible has been met, the equivalent "Wraparound Plus Major Medical" program will pay 80% of the first $2,000 of covered medical expenses for each eligible person, and then increase payment to 100% of covered medical expenses for the rest of that benefit period. This means that we will pay $1,600 and you will be responsible for $400 out-of-pocket in addition to the deductible, before equivalent "Wraparound Plus Major Medical" payment increases to 100% of covered medical expenses.

When two people under the same family have reached the 100% level during the same benefit period, the remaining family members will receive 100% of covered medical expenses for that benefit period.

However, this provision does not apply to covered medical expenses for outpatient and out-of-hospital mental care.

Maximum Benefits

While coverage is in effect, each eligible person is entitled to $1,000,000 to be paid for equivalent "Wraparound Plus Major Medical" expenses incurred during a benefit period and $1,000,000 to be paid for equivalent "Wraparound Plus Major Medical" expenses incurred during his or her lifetime for all covered medical expenses.

Payment for inpatient mental care is limited to $10,000 per benefit period and $20,000 per lifetime for each eligible person.

Reinstatement Of Benefits

Each year on January 1st, each eligible person who then has benefits from the previous benefit period charged against the lifetime maximum, will have the lesser of payments made or $2,000 restored automatically for future use.

If $1,000 or more in benefits is paid under this program, you can have the lifetime maximum fully reinstated by furnishing satisfactory evidence of insurability to us at your expense. You can get the evidence of insurability form from us. The information will be reviewed by us and you will be advised of our decision, including the date for the reinstatement of the lifetime maximum.

Covered Medical Expenses

Covered medical expenses are the reasonable and cutomary charges as determined by us for the following services and supplies when they are performed or prescribed by a physician and are medically necessary for the diagnosis or treatment of an illness or injury:

- Services of a physician who regularly charges for his or her services as a private physician. Charges by any physician in excess of the Plan's reasonable and customary fee for the services performed will NOT be considered a covered medical expense;
- When a physician suggests elective surgery and the eligible person would like a second opinion, information on second opinion consultation services may be obtained from the Plan's Second Opinion Referral Center by calling toll free 1(800) 225-1345;
- Room and board, including special diets and general nursing service in a hospital, but not to exceed, for each day a private room is used, the hospital's average daily semi-private room rate;
- Use of operating, recovery, treatment, delivery and emergency room equipment and facilities;
- Expenses incurred in either an intensive care unit or cardiac care unit of a hospital;
- Medical and surgical dressings, supplies, casts and splints;
- Anesthetics and their administration;
- Diagnostic X-ray and laboratory services;
- Radiation therapy, including administration, materials and supplies, and use of equipment;
- Chemotherapy;
- Oxygen and its administration;

- Physical and rehabilitation therapy;
- Speech therapy services billed for by a hospital or physician, or prescribed by a physician and rendered by a registered speech therapist, to restore speech loss or to correct an impairment due to a congenital defect for which corrective surgery has been performed, or for an accident or a sickness other than a functional nervous disorder;
- Blood transfusions, including cost of blood, blood plasma and blood plasma expanders when it is not donated or replaced through a blood bank or otherwise;
- Drugs, medicines and dressings used in a hospital or health care facility; drugs which by law require a prescription, purchased for use outside a hospital (a drug must be approved by the Food and Drug Administration, but only for FDA-approved uses); Insulin. Experimental drugs and contraceptives are not eligible;
- Services of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) while the patient is in the hospital, and the services or a registered nurse outside the hospital. Charges for the services of a private duty nurse who is an immediate relative or member of the patient's household will be covered for an 8-hour shift in each continuous 24-hour period only if satisfactory proof is furnished that he or she otherwise would have been gainfully employed as a nurse;
- Rental of a wheelchair, hospital bed, oxygen tent or other durable medical equipment required for therapeutic use, or purchase of such equipment if the cost would be less than the rental;
- Prosthetic appliances necessary to alleviate or correct conditions arising out of accidental injury occurring or illness beginning after your effective date under this program;
- Breast prostheses following eligible reconstructive breast surgery;
- Treatment of diseases and injuries of the eye; special eyeglasses and contact lenses which replace the human lenses as a result of intra-ocular surgery or congenital disease (replacement of these contact or eyeglass lenses will be covered when a change in prescription is necessary). The lenses specified in this paragraph will be covered only when they become necessary for the correction of conditions arising out of injury or illness occurring while the eligible person is covered under this program;
- Eligible outpatient surgical services performed at a surgical center;
- Services provided by a detoxification facility for the treatment of alcoholism consisting of:
  - Bed and board in a semi-private room;
  - General nursing services;
  - Services of the staff (voluntary or paid employees of the facility) including necessary trained professionals contracted or paid for by the facility;
  - Biologicals, solutions, drugs, medicines and medications used while the patient is in the facility and which, at the time prescribed, are in commercial production and commercially available to the facility;

- Laboratory tests necessary for patient care (but not X-rays);
- Psychological testing by a licensed psychologist;
- Individual and group therapy or counseling;
- Family counseling;
- Occupational therapy (but not diversional or recreational therapy or activity).

Rehabilitation services on an ambulatory basis, prescribed by a licensed physician, and provided under a program approved by the New Jersey State Division of Alcoholism (or in other states, as approved by that state), will be covered when provided as outpatient services by an approved hospital or residential facility or as aftercare by a detoxification facility. The eligible rehabilitation services are:

- Services of staff, including necessary trained professionals;
- Individual and group therapy or counseling;
- Family counseling;
- Initial diagnostic evaluation in the outpatient department or clinic of a hospital.

You are entitled to benefits for your physician's inpatient medical visits for acute care and treatment of alcoholism during a covered hospital admission;

- Professional ambulance service (surface transportation only) used locally to or from the hospital except in connection with outpatient care of non-accidental illness;
- Services billed for by, and payable to, an approved skilled nursing facility for room and board and general nursing service, when the admission is within 14 days of discharge from a hospital and is for continuing treatment prescribed by a physician. Benefits are available for each day of service but not to exceed a daily maximum based on the average semi-private room rate for 120 days of care during any one benefit period;
- Dental treatment, dental surgery or dental appliances made necessary by accidental bodily injury occurring while the eligible person is covered under this program; extraction of bony impacted teeth and dental surgical services recognized as common to both the medical and dental professions such as treatment of malignancy of the mouth;
- Physician services for any obstetrical condition including childbirth, abortion or miscarriage, for an enrolled employee or enrolled spouse of an employee. **Child dependents are not eligible for obstetrical care;**
- Medical care of a healthy newborn child during the joint hospital stay of mother and child by a physician other than the one who performs maternity services;
- Benefits for outpatient and out-of-hospital mental care include the expenses described under this section when received in the outpatient department of a

hospital or outside a hospital. Benefits also include the services and supplies of approved day-care and night-care treatment centers; psychotherapeutic services such as individual counseling, family counseling, group therapy, and electroshock therapy rendered by a physician or a mental health team (physician, and one or more of the following - psychiatric nurse and psychiatric social worker);
- We will pay 80% of covered medical expenses (physician's visits, day-care and night-care, prescription drugs, etc.) in excess of the deductible for outpatient and out-of-hospital mental care.

How To Claim Benefits

When To Submit A Claim

When eligible expenses not covered by your basic Hospital program exceed your deductible within your benefit period, you may file a claim.

If you receive services from a physician, he or she should bill us directly. You and the physician must complete the Service Report required by us.

Claim forms for filing all equivalent "Wraparound Plus Major Medical" claims are available from us and will be furnished to your employer or to you upon request.

Itemized Bills

You must obtain itemized bills from the providers of services for all covered medical expenses except for physician services. Your physician should bill us directly for eligible services. The itemized bills must include the following:

- Name and address of provider;
- Name of patient;
- Date of service;
- Type of service;
- Charge for each service.

Bills for services of private duty nurses must show that the nurse is a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) and must include his or her license number. Along with the bill, you must submit a letter from the attending physician certifying that the services of the nurse were medically necessary and not provided as a convenience for you or for your family.

Itemized bills for prescription drugs must also show the name of the patient and prescription number and the name and quantity of the drug provided.

If payment has been made by another carrier or Medicare for any of the expenses being submitted to us, you must include the original copy of the explanation of benefits from the carrier or Medicare along with the itemized bills and receipts.

Completing The Equivalent "Wraparound Plus Major Medical" Claim Form

Be sure to fill out the claim form completely. Include your identification number. This number appears on your identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

When your physician bills us directly, you are responsible for having the physician complete the "Physicians Statement" on the Claim Form.

Submitting Your Claim

Send each completed equivalent "Wraparound Plus Major Medical" claim form together with all itemized bills that apply to the claim to the address shown on the claim form. When your physician completes the Service Report, you are responsible for having the completed Service Report forwarded to us.

Once you have satisfied your deductible and have submitted your first claim, send additional claims for covered medical expenses whenever covered expenses exceed $100 or whenever a lesser amount has been incurred and four months have passed from the time you submitted your first claim. Claims for equivalent "Wraparound Plus Major Medical" benefits must be submitted no later than December 31 of the calendar year following the year in which expenses were incurred.

If, for any reason, the claim you submit to us is not eligible, you will be notified within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section of this booklet.

Payment Of Claims

Payment will be made to physicians if he or she bills us directly for his or her services eligible for coverage under the equivalent "Wraparound Plus Major Medical" program and you have assigned benefits directly to the physician.

Exclusions Under Your "Wraparound Plus Major Medical" Program

The following services are not covered under your equivalent "Wraparound Plus Major Medical" program:

- Any service that does not meet the medical necessity or level of care requirements of this program;
- Service for any sickness, disease or injury occurring during military service;
- Disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
- Services for any sickness, disease, or injury arising out of or in the course of employment and for which benefits and/or compensation are wholly or partially available under any Worker's Compensation, occupational disease, unemployment, temporary disability benefits or compensation law or any similar legislation whether or not the person asserts his or her rights under such legislation and whether or not there are recoveries against third parties for damages;
- Services and/or supplies furnished under the laws of the United States, of any State, of any foreign country or of any subdivision or agency of any of the foregoing;
- Services or supplies for cosmetic purposes except for the correction of defects incurred through traumatic injuries sustained by you while covered under this program;
- Services received prior to the effective date of coverage under this program;
- Services or supplies in connection with any procedure or examination not incident to, or necessary for, diagnosis of any injury or sickness for which a bonafide provisional diagnosis has been made because of existing symptoms;
- Services or supplies not specifically listed in this booklet as covered medical expenses;
- Travel, whether or not recommended by a physician;
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the eligible person enrolled, applied or maintained eligibility for such benefits under Medicare. If you are eligible for Medicare, the benefits of this program are reduced to the extent that benefits for the services are available under Medicare;
- Convalescent, custodial or sanatorium care or rest cures;
- Durable medical equipment which is primarily for comfort or convenience rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, heating pads and similar supplies which are useful to a person in the absence of illness or injury;
- Services rendered for screening or research studies or experimental procedures, treatments, facilities, equipment, drugs, devices or supplies;

- Services for which no charge usually would be made to the patient, or if made, usually would not be collected if no health benefits coverage existed;
- Diversional/recreational therapy or activity;
- Services of a licensed practical nurse (L.P.N.) outside a Hospital;
- Services under your equivalent "Wraparound Plus Major Medical" program to the extent benefits for such services are available under the Hospital program, whether or not the eligible person is enrolled for such coverage;
- Any deductible or copayment applicable to Hospital benefits provided under basic coverage;
- Dental care and treatments, dental surgery or dental appliances except as specified under the covered medical expenses in this booklet;
- Hearing aids or eyeglasses or examinations for the prescription or fitting of them except as specified under the covered medical expenses section of this booklet;
- Services for any condition related to the pregnancy of a child dependent; routine care of a healthy newborn infant except as specified under the covered medical expenses section of this booklet;
- Services which are not prescribed or performed by or upon the direction of a physician or eligible provider;
- Services for any condition, including alcoholism treatment, will be provided only for the length of time and at the level of care . . . hospital, detoxification facility, residential facility, ambulatory care . . . medically necessary for the patient's condition. The non-availability of other facilities will not be considered a valid reason for admitting a patient to a higher level of care that is medically required for his condition.

Services For Automobile Related Injuries

Under this program, the Plan will provide secondary coverage to PIP unless the Plan has been elected as primary coverage by or for the Eligible Person covered under this contract. This election is made by the named insured under the PIP policy and affects that person's family members who are not themselves the named insured under another auto policy. The Plan may be primary for one Eligible Person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Plan is secondary to Other Automobile Insurance Coverage. However, if the Other Automobile Insurance contains provisions which made it secondary or excess to the Plan, then the Plan will be primary.

If there is a dispute as to whether the Plan is primary or secondary, the Plan will pay benefits as if it were primary.

If the Plan is primary to PIP or other Automobile Insurance Coverage, it will pay benefits subject to the terms, conditions and limits set forth in your Contract and only for those services normally covered under your Contract.

If the Plan is one of several health insurance plans which provide benefits for Automobile Related Injuries and the Eligible Person has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If the Plan is secondary to PIP, the actual benefits payable will be the lesser of:

a. the remaining uncovered allowable expenses after PIP has provided coverage after application of co-payments, or

b. the actual benefits that would have been payable had the Plan been providing coverage primary to PIP.

Medicare And Your Benefits

If you are eligible for Medicare, actively working and are age 65 or over; or if your spouse is eligible for Medicare and age 65 or over, while you are actively working; you and/or your spouse have the opportunity to choose either this program or Medicare as your primary health benefits program.

If you choose Medicare, your Hospital and equivalent "Wraparound Plus Major Medical" benefits will end for you and your eligible dependents.

If you choose this program as your primary coverage, you and your eligible dependents will continue to be eligible for the benefits described in this booklet, and Medicare will supplement these benefits.

Contact your enrollment official for further details about your eligibility for Medicare or Hospital and equivalent "Wraparound Plus Major Medical" benefits when you reach age 65.

If you are eligible for Medicare, under or over age 65 and not actively working, this coverage will be reduced by any amount that Medicare will pay for those services. If applicable, this reduction will be made whether or not you claim or receive the benefits available under Medicare. If you are in this category, you should contact your enrollment official for further information.

If your employer employs 100 or more and you are under age 65 and are disabled, then the benefits of this program may be primary. If applicable, Medicare will supplement these benefits. You should contact your enrollment official for further information.

How To File An Equivalent "Wraparound Plus Major Medical" Claim If You Are Eligible For Medicare

Follow the procedure that applies to you from the categories listed below when filing your equivalent "Wraparound Plus Major Medical" claim.

New Jersey Physicians Or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The physician or provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, you will receive an Explanation of Benefits form from Medicare;
- If the remark's section of the Explanation of Benefits contains the following statement, you need not take any action. "This information has been forwarded to IDA for their consideration in processing supplementary coverage benefits";
- If the above statement does not appear on the form, you should indicate your identification number and the name and address of the physician or provider in the remarks section and send it to us.

Out-Of-State Physicians Or Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed;
- When you receive the Explanation of Benefits form, indicate in the remarks section your identification number and the name and address of the physician or provider and send the form to us for processing.

Out-Of-Country Physicians Or Providers:

Medicare will provide benefits for services of a physician or provider out of the country under the following instances:

- When an emergency arises while the Medicare recipient is in the United States, and the nearest source of adequate hospital care is in Canada or Mexico;

- If the Medicare recipient resides in the United States, but the nearest source of non-emergency hospital care is in Canada or Mexico;
- When the Medicare recipient is traveling between Alaska and another state and an emergency occurs requiring hospitalization in a Canadian hospital.

If you incur a claim in any of the above circumstances, any Social Security office will help you complete the Request for Medicare Payment. The Request for Payment should then be sent to the Medicare Part B carrier in the area where you reside.

When you receive the Explanation of Benefits form, you should proceed in the same manner as you would if you were submitting a claim to us from a New Jersey physician or provider.

As Medicare provides virtually no benefits for services performed in a foreign country, we will provide full benefits (within the limits of your group's contract) for eligible claims incurred out of the country.

You should pay the person performing the services and then obtain an itemized bill containing the following information:

- The date of service(s);
- The specific service(s) performed;
- The charges;
- Your identification number;
- The patient's name and, if the patient is your dependent, your name and address;
- If the bill is in a foreign language, a brief description in English of the services performed;
- The itemized bill should than be sent to us. We will pay you directly. Any balances over our payment are your responsibility.

Claims Appeal

You or your authorized representative may appeal and request us to reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the limitations and/or exclusions of your program.

This inquiry may be made by either telephoning our Service Centers at one of the numbers listed at the back of this booklet or by writing to Insurance Design Administrators, P.O. Box 875, 3 Post Road, Oakland, New Jersey 07436.

The following information must be given at the time of each telephone or written inquiry:

- Name(s) and address(es) of patient and subscriber;
- Subscriber's identification number;
- Date(s) of service(s);
- Provider's name . . . for example, hospital, detoxification facility, residential facility, or physician;
- Reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim which was not given to us when the claim was first submitted, be sure to include it.

Upon request, you have the right to review pertinent documents. Copies of your group's contract are available from your employer. A copy of other material relative to your claim will be made available from us. In some cases, written authorization from your attending physician to release certain information will be necessary and you will be informed accordingly.

Inquiries should be made within 12 months of the date you were first notified of the action taken to deny all or part of your claim. Upon receipt of the written inquiry, your claim will be researched and reviewed thoroughly and you will be notified of the decision on your appeal within 60 days of receipt of the appeal. However, special circumstances, such as delays by you or the provider in submitting necessary information, may require an extension of this 60-day period.

If legal action is brought against us for a claim that has been wholly or partially denied, the action must be brought within 12 months of the first denial, or if the claim has been appealed, within 12 months of the denial of the appeal.

When you need to call us, identify yourself and the group program through which you are enrolled. Also give your identification number. Space is provided to write in names, addresses and phone numbers on the last page of this booklet.

Coordination Of Benefits

Almost all group insurance programs provide for the coordination of benefits. A program without such a provision is automatically the primary program whenever its benefits are duplicated. For programs that do have this provision, the following rules determine which one is the primary program:

- If you are the patient, then this program is the primary program. If your spouse is the patient and covered under a program of his or her own, then that program is the primary program.

- If a dependent child is the patient and is covered under both parents' programs, the following birthday rule will apply:

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday if July 16 and mother's birthday is May 17, the mother's plan would be primary for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary. **Only the month and the day (not the year) of each parent's birthday is used to determine which plan is primary.**

This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

- If two or more programs cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order:

    - The program of the parent with custody is primary;
    - The program of the spouse of the parent with custody of the child;
    - The program of the parent not having custody of the child. However, if it has been established by a court decree that one parent has responsibility for the child's health care expenses, then the program of that parent is primary.

The benefits of the program which covers a person as an active employee or his dependents will be determined before the benefits of a program which covers such person as a laid-off or retired employee or his dependent. If the other benefit program does not have this rule and, as a result, do not agree on the order of benefits, this rule will not apply.

- If none of the above rules determine the order of benefits, the program that has covered the patient for the longer period is the primary program.

This program will provide its regular benefits in full when it is the primary plan. As a secondary plan, this program will provide a reduced amount which when added to the benefits under other group plans will equal up to 100% of the charges for the patient's eligible expenses under this program, but in no event will this program's liability as a secondary plan exceed its liability as a primary plan.

If you have any questions about this program, call Insurance Design Administrators.

Telephone personnel are available Monday through Friday from 8:30 a.m. to 4:30 p.m.

For the Hospital and equivalent "Wraparound Plus Major Medical" programs call:

(201) 337-0555
(800) 225-1345

Always have your identification card handy when calling us. Your ID number helps us get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

_____

The identification number shown on my identification card:

_____

The effective date when my coverage begins:

_____

Benefit Limits

(1) Mental Disorders and Substance Abuse Treatment (drug related) Limits

Inpatient care is paid as any other Sickness

Network Provider

Outpatient copayment.....	$10.00; then 100%

Non-network

Outpatient percentage payable.....	80% after deductible

Network and Non-Network

Calendar Year maximum.....	Inpatient days plus $10,000
Lifetime maximum.....	Inpatient days plus $20,000

The 100% benefit provision is not applicable to any charges for Non-Network (out-of-network) outpatient mental disorders and substance abuse (drug related) services and never paid at 100%.

PRESCRIPTION DRUG CARD PLAN

Pharmacy Option

Copayment, per prescription filled or refilled

Name Brands.....	$5.00
Generic Drugs.....	$0.00

Mail Order Option

Copayment, per prescription filled or refilled

Name Brands.....	$5.00
Generic Drugs.....	$0.00

BENEFIT SUMMARY - PLAN I
County of Passaic

BENEFIT DESIGNS	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES** •Per Calendar Year	•Per Person	NA	$200**
	•Per Family (Cumulative)	NA	$400**
PLAN COVERAGE	•Percentage payable	90% or 100% (where applicable)	80% or 100% (where applicable)
OUT OF POCKET MAXIMUM •Per Calendar Year •IMPORTANT - The OUT-OF-POCKET MAXIMUMS are combined totals both In & Out-of-Network	•Per Person •Per Family (Two (2) Covered Persons must each satisfy the maximum out-of-pocket) •INCLUDING APPLICABLE DEDUCTIBLES	$150 $300 When the Annual Coinsurance payments (out-of-pocket) equal $150 per person/$300 per family, the 100% benefit provision will apply for all eligible charges for all eligible covered family members for the balance of that Calendar Year	$ 600 $1,200 When the Annual Coinsurance payments (out-of-pocket) equal $600 per person/$1,200 per family, the 100% benefit provision will apply for all eligible charges for all eligible covered family members for the balance of that Calendar Year
INDIVIDUAL LIFETIME MAXIMUM	•Per Person	$1,000,000	
PHYSICIAN SERVICES	•Inpatient Visits •General Conditions •Alcoholism •Nursery Newborn Care	100% Coverage	100% Coverage
	•Inpatient Visits •Mental Disorders •Substance Abuse (Drug Related)	30 Days @ 100%; then 90% Coverage; 10% Coinsurance	30 Days @ 100%; then Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Surgery •Assistant Surgeon •Anesthesia •Usual & Reasonable Fees Apply	100% Coverage	100% Coverage
	•Physician/Specialist office visits	$10 Copayment; 100% Coverage	Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Chiropractic Services	90% Coverage 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance
SECOND SURGICAL OPINION ●	•Physician other than one performing the surgical procedure	100% Coverage	100% Coverage
MATERNITY ●	•Treated the same as any other Sickness •Usual & Reasonable Fees Apply	100% Coverage	100% Coverage

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

** Deductibles: $200 per Person per Calendar Year
$400 per Family per Calendar Year (Cumulative)

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

• OUT-OF-NETWORK BENEFITS - All services performed by a Non-Network (Out-of-Network) Provider will be subject to the Usual and Reasonable Fees charged for that procedure or service.

● Certification Required for In & Out-of-Network Services - Non Compliance Penalty - Inpatient Admissions/Surgical Procedures not precertified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

Ambulance Service - per trip maximum..... the Usual and Reasonable Charge

Shock Therapy -
benefit limit per Calendar Year..... 12 treatments

Hospice Care Limits -
lifetime benefit limit..... $10,000

Respite Care -
lifetime benefit limit..... 10 visits

Routine Pap Smear -
benefit limit per Calendar Year..... One

Routine Mammography - Frequency Limit

Age 35-39..... One baseline mammogram

Age 40-49..... One mammogram every two years

Age 50 and over..... One mammogram annually

Network and N Network Providers

Birthing Centers.....	100%
Surgical Centers.....	100%
Detoxification and Residential Facility.....	100%
Hospice Care.....	100%
Freestanding Dialysis/ Transfusion Care.....	100%

Out of Area Emergency Care

To receive In-Network Benefits for Out of Area Emergency Care a Covered Person must call the Utilization Management Service within the first 48 hours of the medical emergency treatment.

Maximum Benefit Amount (subject to adjustments shown under Benefit Limit(s)

Lifetime, while covered.....	$1,000,000
Hospital daily room and board limit.....	the average semiprivate room rate
Intensive Care Unit daily limit.....	Hospital's ICU/CCU/NNU charge
Skilled Nursing Facility - covered daily charge limit.....	the facility's average semiprivate room rate

BENEFIT SUMMARY - Plan I
County of Passaic

BENEFIT DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
ASSOCIATED MEDICAL SERVICES •Professional and/or Facility (Outpatient/Out-of-Hospital) •Procedure and its interpretation	•Diagnostic X-rays •CAT Scan •MRI •Other diagnostic x-rays	$125 @ 100%; 90% Coverage; 10% Coinsurance	$125 @ 100%; Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Laboratory & Pathology •Electrocardiograms •Electroencephalograms	$50 @ 100%; 90% Coverage; 10% Coinsurance	$50 @ 100%; Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Chemotherapy & Radiation Therapy	$500 @ 100%; 90% Coverage; 10% Coinsurance	$500 @ 100%; Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Radium, Radioactive Isotope, and Radon Therapy	100% Coverage	$150 @ 100%; Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Pap Smear# •Mammography #	100% Coverage	Refer to Specific Benefit Provision - Associated Medical Services Basic Benefits; then Deductibles Apply** 80% Coverage; 20% Coinsurance
HOSPITAL INPATIENT @ •General Conditions •Alcoholism	•Unlimited Days Semi-Private Room/Board •Other Hospital provided Services, Facilities, Supplies & Equipment •Intensive/Coronary Care/Neonatal/Burn Unit •Physician Care - See Physician Services •Inpatient Consultation (one per stay) & Physician requested	100% Coverage	120 Days @ 100%; $5 per day @ 100% days 121- 365 then Deductibles Apply** 80% Coverage; 20% Coinsurance
HOSPITAL OUTPATIENT	•Ambulatory Surgery (includes Surgery Center Confinement) @	100% Coverage	100% Coverage
	•Surgery @ (Physician Services only) •Usual & Reasonable Fees Apply	100% Coverage	100% Coverage
	•Pre-admission Testing •Blood •Home Dialysis billed by hospital •Each treatment counts as 1 benefit day •Accidental Injury (within 48 hours) •Detoxification •Treatment for Poisoning •Cardioversion •Removal of orthopedic hardware •Transfusion Services	100% Coverage	100% Coverage
	•Chemotherapy & Radiation Therapy •Laboratory & Pathology •Diagnostic X-ray & Testing •Refer to Associated Medical Service for outpatient benefit •Note - These services are considered separate and combined totals for service performed outpatient & out-of-hospital	100% Coverage	See Associated Medical Services

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

** Deductibles: $200 per Person per Calendar Year
$400 per Family per Calendar Year (Cumulative)

#NOTE: Routine Pap Smear, one per Calendar Year
Mammography - Frequency Limit -
Age 35-39 one baseline
Age 40-49 one every two years
Age 50 & over one per year

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

• OUT-OF-NETWORK BENEFITS - All services performed by a Non-Network (Out-of-Network) Provider will be subject to the Usual and Reasonable Fees charged for that procedure or service.

@ Certification Required for In & Out-of-Network Services - Non Compliance Penalty - Inpatient Admissions/Surgical Procedures not precertified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

BENEFIT SUMMARY - Plan I
County of Passaic

BENEFITS DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
MENTAL DISORDERS & SUBSTANCE ABUSE SERVICES ● •Inpatient Mental Disorders •Inpatient Substance Abuse (Drug Related) •IMPORTANT - Limited* •Calendar Year Maximum - Inpatient Days plus Dollar Amount (See Maximum Benefits)*	•Semi-private Room & Board, other Hospital provided Services & Supplies •Day Limit per confinement @ 100% •Physician Care - See Physician Services •Shock Therapy (12 Treatments) •Combined benefits payable for In & Out-of-Network* •Combined Calendar & Lifetime Maximums for In & Out-of-Network/Inpatient & Outpatient*	20 Days @ 100%; then 90% Coverage; 10% Coinsurance Maximum Benefits Apply*	20 Days @ 100%; then Deductibles Apply** 80% Coverage; 20% Coinsurance Maximum Benefits Apply*
•Inpatient Substance Abuse (Alcoholism only) •Refer to In-patient Hospital Service for Benefit Days	•Covered on the same basis as any other medical condition •Inpatient days - See Inpatient Hospital for General Conditions & Alcoholism •Physician Care - See Physician Services	100% Coverage See Inpatient Hospital Services	100% Coverage See Inpatient Hospital Services
MENTAL DISORDERS/ SUBSTANCE ABUSE CARE● (Drug Related) •Intermediate Care Facility •IMPORTANT - Limited*	•Day limit confinement @ 100% (see Inpatient Days - combined) •Combined benefits payable & Maximums apply In & Out-of-Network*	20 Days @ 100%; then 90% Coverage; 10% Coinsurance Maximum Benefits Apply*	20 Days @ 100%; then Deductibles Apply** 80% Coverage; 20% Coinsurance Maximum Benefits Apply*
SUBSTANCE ABUSE ● (Alcoholism) •Detoxification & Residential Facility •Intermediate Care Facility	•Covered on the same basis as any other medical condition •Inpatient Days - See Inpatient Hospital for General Conditions & Alcoholism •Lab & psychological testing •Individual, group & family counseling & therapy	100% Coverage See Inpatient Hospital Services	100% Coverage See Inpatient Hospital Services
MENTAL DISORDERS & SUBSTANCE ABUSE (Drug Related) •Outpatient Services	•Outpatient/Out-of-hospital - including services, supplies for day care/night care treatment centers •Individual, group & family counseling & therapy •Electroshock therapy •Calendar Year Maximum applies* •Combined In & Out-of-Network Benefits payable •Combined with Inpatient for Calendar Year & Lifetime Totals* •100% Benefit provision not applicable Out-of-Network	$10 Copayment; 100% Coverage Maximum Benefits Apply*	Deductibles Apply** 80% Coverage; 20% Coinsurance Maximum Benefits Apply* 100% Benefit Provision not applicable
•Outpatient Substance Abuse (Alcoholism)	•Covered on the basis as any other medical condition	$10 Copayment; 100% Coverage	Deductibles Apply** 80% Coverage; 20% Coinsurance
MAXIMUM BENEFITS FOR MENTAL DISORDERS & SUBSTANCE ABUSE (Drug Related)	•Combined Calendar Year & Lifetime Maximum, In & Out-of-Network, Inpatient/Outpatient*	Inpatient Days plus •$10,000 Calendar Year* •$20,000 Lifetime*	
AMBULANCE	•Billed Separately	90% Coverage; 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance

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

** Deductibles: $200 per Person per Calendar Year
$400 per Family per Calendar Year (Cumulative)

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

• OUT-OF-NETWORK BENEFITS - All services performed by a Non-Network (Out-of-Network) Provider will be subject to the Usual and Reasonable Fees charged for that procedure or service.

● Certification Required for In & Out-of-Network Services - Non Compliance Penalty - Inpatient Admissions/Surgical Procedures not precertified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

Physical Therapy..... $5 100%; then 80% after the deductible

ADDITIONAL SERVICES

Skilled Nursing Facility..... 30 Days* @ 100%; then 80% after the deductible

* Note: **Every two (2) days in a Skilled Nursing Facility will count as one inpatient benefit day.**

Home Health Care..... 60 Days* @ 100%; then 80% after the deductible

* Note: **Every three (3) home health care visits will count as one benefit day for inpatient care.**

Hospital Emergency Room..... 80% after the deductible
(medical conditions)

Chiropractic Services..... 80% after the deductible

Speech Therapy..... 80% after the deductible

Occupational Therapy..... 80% after the deductible

Ambulance..... 80% after the deductible

Outpatient Private Duty Nursing..... 80% after the deductible

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Outpatient hospital care and services.....	100%
Accidental Injury..... (initial treatment within 48 hours)	100% for initial visit; then 80% after deductible (Refer to specific benefit provisions which may apply for additional services payable at 100%)
Accidental Injury..... (initial treatment after 48 hours)	80% after the deductible (Refer to specific benefit provisions which may apply for additional services payable at 100%)

ASSOCIATED MEDICAL SERVICES

Diagnostic Xrays.....	$125 @ 100%; then 80% after the deductible
Laboratory/Pathology.....	$ 50 @ 100%; then 80% after the deductible
Chemotherapy & Radiation Therapy.....	$500 @ 100%; then 80% after the deductible
Radium, Radiation Isotope and Radon Therapy.....	$150 @ 100%; then 80% after the deductible

BENEFIT SUMMARY - Plan I
County of Passaic

BENEFITS DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SHORT TERM REHABILITATION	•Physical Therapy	$50 @ 100%; then 90% Coverage; 10% Coinsurance	$50 @ 100%; then Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Speech Therapy •Occupational Therapy	90% Coverage 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance
EMERGENCY SERVICES @ •Use of Emergency Facility •Copayment per visit waived if admitted •Utilization Management notification & authorization required within 48 hrs. only if admitted •Out-of-Area Emergency Services - Utilization Management notification & authorization required within 48 hrs. for In-Network Benefits •IMPORTANT - Refer to Plan Provisions which may apply for Out-of-Network Providers & Services	•Benefits apply per incident for all services for the first 48 hrs. for the following: •Accidental Injury	100% Coverage within 48 hours for Initial Services/ Treatment Initial Treatment after 48 hours $25 Copayment; 100% Coverage	100% Coverage for Initial Emergency Services/Treatment only of within 48 hours; then Basic Benefit Provisions (if applicable) Deductibles Apply** 80% Coverage; 20% Coinsurance Initial Services rendered after 48 hours; Deductibles Apply** 80% Coverage; 20% Coinsurance
	•Medical condition Non-Emergency - For Emergency Room only	90% Coverage; 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance
HOME HEALTH CARE •Refer to eligible Inpatient Hospital Days	•Medically Necessary •Treatment Plan prescribed & monitored by Attending Physician •Skilled Nursing services/ Home health aides •Physician visits limited one per week, 16 visits in 120 day period •60 visits within 120 days following hospital discharge or in lieu of hospital confinement •Every three (3) visits equal one (1) benefit day	60 Days @ 100%; then 90% Coverage; 10% Coinsurance	60 Days @ 100%; then Deductibles Apply** 80% Coverage; 20% Coinsurance
SKILLED NURSING & REHABILITATION FACILITY @ •Refer to eligible Inpatient Hospital Days	•Inpatient Benefit Days Apply •Every two (2) days equal one (1) benefit day •Semi-Private Room accommodations •Consistent with diagnosis and immediately following a covered hospital confinement	30 Days @ 100% each confinement; then 90% Coverage; 10% Coinsurance	30 Days @ 100% each confinement; then Deductibles Apply** 80% Coverage; 20% Coinsurance
OUTPATIENT PRIVATE DUTY NURSING	•Medically Necessary •Physician recommendation	90% Coverage; 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance
BIRTHING CENTERS @ •Professional/Facility Services (where applicable)	•Physician Care - See Physician Services	100% Coverage	100% Coverage - Facility Physician Care - See Physician Services
SURGICAL CENTERS @ •Professional/Facility Services (where applicable)	•Admission & discharge within 24 hours •Physician Care - See Physician Services	100% Coverage	100% Coverage

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

** Deductibles: $200 per Person per Calendar Year
$400 per Family per Calendar Year (Cumulative)

NOTE: • OUT-OF-NETWORK BENEFITS - All services performed by a Non-Network (Out-of-Network) Provider will be subject to the Usual and Reasonable Fees charged for that procedure or service.

@ Certification Required for In & Out-of-Network Services - Non Compliance Penalty - Inpatient Admissions/Surgical Procedures not precertified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

BENEFIT SUMMARY - Plan I
County of Passaic

BENEFITS DESIGN	PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
FREESTANDING DIALYSIS CENTER	• Each treatment will be considered as one benefit day	100% Coverage	100% Coverage
TRANSFUSION SERVICES	• Administration of direct transfusions	100% Coverage	100% Coverage
HOME HEMOPHILIA BENEFIT • Supervision by a State approved hemophilia treatment center	• Training for self-administration of home treatments • Blood products • Blood infusion equipment	100% Coverage	100% Coverage
HOSPICE CARE ● • IMPORTANT - Limited* • Lifetime Maximum - $10,000 • Refer to Plan Provisions which apply	• Facility & Physician Services • Diagnostic & nursing services, acute care, therapy, medical, surgical, durable medical equipment, oxygen & administration, psychological support & family counseling, dietician service • Respite Care - limited to 10 day maximum per Calendar Year	100% Coverage Maximum Benefit Applies*	100% Coverage Maximum Benefit Applies*
PROSTHETIC & ORTHOTIC APPLIANCES & DURABLE MEDICAL EQUIPMENT & SUPPLIES	• Medically Necessary • Physician Prescribed • Breast Prosthesis following surgery • Dental Prosthesis within 12 months of accidental injury • Hair/Scalp following chemo/radiation therapy • Other appliances/equipment/supplies	90% Coverage 10% Coinsurance	Deductibles Apply** 80% Coverage; 20% Coinsurance
HUMAN ORGAN TRANSPLANTS● • Prior Authorization required • Refer to other Plan Provisions which may apply	• Medically Necessary • Non-Experimental	Refer to Plan Provisions applicable	Refer to Plan Provisions applicable

* All Limitations and Maximum Totals are combined in and Out-of-Network unless otherwise noted.

** Deductibles: $200 per Person per Calendar Year
$400 per Family per Calendar Year (Cumulative)

NOTE: • OUT-OF-NETWORK BENEFITS - All services performed by a Non-Network (Out-of-Network) Provider will be subject to the Usual and Reasonable Fees charged for that procedure or service.

● Certification Required for In & Out-of-Network Services - Non Compliance Penalty - Inpatient Admissions/Surgical Procedures not precertified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

PRESCRIPTION DRUG CARD PLAN		
PRESCRIPTION DRUG/MEDICATIONS • Pharmacy Option • Federal Legend Drugs • State Restricted Drugs • Compound Medications • Insulin (by prescription only) • Fertility Drugs • Drugs for Tobacco Dependency	• Copayment per prescription filled or refilled • Prescribed by a licensed physician and dispensed by a licensed pharmacist medically necessary to treat a medical condition	$0.00 Generic Drugs $5.00 Name Brands
• Mail Order Option • Federal Legend Drugs • State Restricted Drugs • Compound Medications • Insulin (by prescription only) • Aids Medications • Fertility Drugs • Drugs for Tobacco Dependency	• Copayment per prescription filled or refilled • Prescribed by a licensed physician and dispensed by a licensed pharmacist medically necessary to treat a medical condition	$0.00 Generic Drugs $5.00 Name Brands

Percentage Payable, per Calendar Year

Non-Network Providers

Hospital care and services..... (General Conditions/Alcoholism)	120 Days* @ 100%; $5 per day @ 100% days 121-365; then 80% after the deductible
Hospital care and services..... (Mental Disorders/Substance Abuse [drug related])	20 Days* @ 100%; then 80% after the deductible
Physician care and services..... (Inpatient-General Conditions/Alcoholism)	100%
Physician care and services..... (Mental Disorders/Substance Abuse [drug related])	30 Days* @ 100%; then 80% after the deductible

* Note: Benefit days renew on the date a new benefit year starts, provided that, for related conditions, 90 days or more have passed from the date on which inpatient or home care services were last received from an eligible provider.

If a Covered Person is in a facility or receiving home health care services at the time the benefit days would renew, the Covered Person will be covered only for the unused number of days from the benefit year in effect when the admission occurred.

Physician/Specialist office visit & services.....	80% after the deductible
Surgery.....	100%

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Hospital Emergency Room (medical conditions)	90%
Chiropractic Services	90%
Speech Therapy	90%
Occupational Therapy	90%
Ambulance	90%
Outpatient Private Duty Nursing	90%

COST CONTAINMENT BENEFITS

The Utilization Management Service

1-800-535-3647 First Option Health Plan
1-800-856-5693 Mental Health Network

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

Utilization Management consists of the following:

* Certification of the Medical Necessity for all non-emergency Hospital or inpatient admissions before medical services are provided;
* Retrospective review of the Medical Necessity for all emergency Hospital admissions;
* Concurrent review, based on the admitting diagnosis, of the number of days of Hospital confinement requested by the attending Physician; and
* Certification of the length of confinement and discharge planning.

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

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

INPATIENT PRE-ADMISSION CERTIFICATION REQUIREMENTS

A Covered Person, physician or relative should certify:

* A non-emergency Hospital or inpatient admission at least five (5) business days in advance of a scheduled inpatient admission.
* An emergency admission (those admissions which cannot be scheduled in advance) within 48 hours or by the next business day following the admission.
* For maternity admissions during the first trimester and within two (2) business days following hospitalization.

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

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

It is the responsibility of the Covered Person and/or Covered Dependent to inform the Physician and/or Hospital that the Plan has a Pre-Admission Certification Program.

Inpatient admissions not certified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

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

CONCURRENT STAY REVIEW/DISCHARGED PLANNING

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

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

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

Accidental Injury..... **(initial treatment within 48 hours)**	100%
Accidental Injury..... **(initial treatment after 48 hours)**	100% after $25.00 copayment

ASSOCIATED MEDICAL SERVICES

Diagnostic Xrays.....	$125 @ 100%; then 90%
Laboratory/Pathology.....	$ 50 @ 100%; then 90%
Chemotherapy & Radiation Therapy.....	$500 @ 100%; then 90%
Radium, Radiation Isotope and Radon Therapy.....	$150 @ 100%; then 90%
Physical Therapy.....	$ 50 @ 100%; then 90%

ADDITIONAL SERVICES

Skilled Nursing Facility.....	30 Days* @ 100%; then 90%

* **Note: Every two (2) days in a Skilled Nursing Facility will count as one inpatient benefit day.**

Home Health Care.....	60 Days* @ 100%; then 90%

* **Note: Every three (3) home health care visits will count as one benefit day for inpatient care.**

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Percentage Pay , per Calendar Year

Network Providers

Hospital care and services..... (General Conditions/Alcoholism)	100%
Hospital care and services..... (Mental Disorders/Substance Abuse [drug related])	20 Days* @ 100%; then 90%
Physician care and services..... (Inpatient-General Conditions/Alcoholism)	100%
Physician care and services..... (Mental Disorders/Substance Abuse [drug related])	30 Days* @ 100%; then 90%

* Note: **Benefit days renew on the date a new benefit year starts, provided that, for related conditions, 90 days or more have passed from the date on which inpatient or home care services were last received from an eligible provider.**

If a Covered Person is in a facility or receiving home health care services at the time the benefit days would renew, the Covered Person will be covered only for the unused number of days from the benefit year in effect when the admission occurred.

Physician/Specialist office visit & services.....	100% after a $10.00 copayment
Surgery.....	100%
Outpatient hospital care and services.....	100%

EMERGENCY SERVICES

In cases of medical emergency, one should go to the nearest emergency facility. To receive maximum benefits for an eligible service, one must contact the *Utilization Management Service* within 48 hours only if admitted. The copayment (if any) will be waived if admitted.

OUT OF THE AREA EMERGENCY CARE SERVICES

When receiving emergency care outside the service area, one must contact the *Utilization Management Service* within 48 hours of treatment to be eligible for maximum benefits.

SURGICAL PROCEDURES & SECOND OPINIONS

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

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

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

If the second opinion does not confirm the need for surgery, a third opinion may be obtained for the recommended surgery. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if the Covered Person desires the procedure. All such consultations will be paid at the rate of 100% of the Usual & Customary Charges. The Plan deductible will also be waived for these consultations.

Surgical procedures not certified or authorized by the Utilization Management Service will result in a 20% reduction of benefits.

SECOND SURGICAL REVIEW LIST

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

Arthroscopy with Meniscectomy (see Meniscectomy)
Bunionectomy (removal of bunions)
Bowel Resection (Removal of portion of bowel)
Bypass Surgery (Coronary, Gastric, Intestinal)
Cataract Extractions
Cholecystectomy (Excision of Gallbladder)
Coronary Artery Bypass (Heart Bypass)
Dilation & Curettage (Expansion & Scraping)
Discectomy (Removal of disc)
Herniorrhaphy (Hernia Procedure)
Hemorrhoidectomy (Removal of Hemorrhoids)
Hysterectomy (Removal of Uterus)
Laminectomy (Spinal Surgery)

Maximum Out-of Pocket expenses for Covered Charges incurred, per Calendar Year, including the applicable Calendar Year deductible.

Network Providers

The Plan pays 100% for certain covered charges and 90% for other covered charges incurred.

When the annual coinsurance payments (out-of-pocket) equals $150 per Covered Person or $300 per Family Unit, the Plan's 100% benefit provision will apply for all eligible charges for all eligible covered family members for the balance of that Calendar Year.

Non-network Providers

The Plan pays 100% for certain covered charges and 80% for other covered charges incurred.

When the annual coinsurance payments (out-of-pocket) equals $600 per Covered Person or $1,200 per Family Unit, the Plan's 100% benefit provision will apply for all eligible charges for all eligible covered family members for the balance of that Calendar Year.

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%, even though they are covered charges.

(1) deductible(s)
(2) copayment(s)
(3) outpatient/out-of-network mental disorder treatment charges
(4) outpatient/out-of-network substance abuse (drug related) treatment charges

A copayment is an amount of money that is paid each time a particular service is used (for example, $10.00 for each Physician visit). Typically, there will be many copayments required on many services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

Network Providers

Physician copayment, per visit.....	$10.00
Emergency room copayment, per emergency..... **(following initial treatment and/or after 48 hours of the incident)**	$25.00

Non-network Providers

Covered Person deductible, per Calendar Year.....	$200
Family Unit deductible per Calendar Year.....	$400 (Cumulative)*

* **Note: When the dollar amount shown has been incurred by the Family Unit toward their Calendar Year deductibles, the deductibles of all covered members of that Family Unit will be considered satisfied for that year.**

Laparotomy (Incision of Abdomen)
Mastectomy (Breast Surgery)
Meniscectomy (Knee Surgery)
Myringotomy (Tube Insertion)
Oophorectomy (Incision of Ovary)
Prostatectomy (Removal or Resection of the Prostate)
Replacement (Total Joint)
Salpingectomy (Removal of Fallopian Tubes)
Salpingo-Oophorectomy (Excision Ovary/Removal of Fallopian Tubes)
Tonsillectomy and/or Adenoidectomy
Chemonucleolysis (Nerve Cell Inflammation)
Valve Replacement
Varicose Vein (Stripping & Ligation)
Nasal Surgery

Any procedure which could be considered cosmetic in nature:

A. Abdominal lipectomy (Excision of fatty tissue)
B. Eyelid surgery
C. Breast reduction or augmentation
D. Mastectomy for gynecomastia (Excision of male mammary glands)
E. Dermabrasion (Skin Abrasions)
F. Otoplasty (Ear plastic surgery)
G. Rhinoplasty (Nose plastic surgery)
H. Rhytidectomy (Wrinkle Removal)
I. Scar revisions

HIGH RISK MATERNITY REVIEW PROGRAM

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

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

The ***Utilization Management Service*** will initiate a second screening during the 24th-26th week gestation. If a risk is identified during this screening the patient's physician is contacted regarding the appropriate treatment planning.

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

LARGE CASE MANAGEMENT

When a medical condition such as a catastrophic condition (spinal cord injury, a degenerative sickness or a neurological paralytic disease) occurs, a person may perhaps require long term or lifetime care. When medical care costs for a particular condition are expected to exceed a certain dollar amount, and there is a potential for alternative treatment or an alternate setting, then the case may be referred for Large Case Management (LCM). LCM is a program which provides an individual case analysis and medical treatment plan recommendations to address the needs of the catastrophically ill or injured individual. The decision to implement LCM will be determined by the stated criteria.

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

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

SCHEDULE OF BENEFITS

Verification of Benefits (800) 446-9972 or (201) 337-0555

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

MEDICAL BENEFITS

The Plan provides a Preferred Provider Organization (PPO).

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

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

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

Deductibles and Copayments Payable, by Plan Participants

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

A **deductible** is the amount of money payable each Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% out-of-pocket payment.

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HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment a person mus.

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

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

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

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

- Name of Plan
- Group Number of Plan (when applicable)
- Employee's name
- Name of patient
- Name, address, telephone & tax identification number of the Provider of Care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges for services

(5) Send the above to the appropriate address listed below:

Submit all In-Network Claims to:

First Option Health Plan
P.O. Box 700
Red Bank, N.J. 07701

Submit all Out-of-Network Claims to:

Insurance Design Administrators
P. O. Box 875
Oakland, New Jersey 07436

County of Passaic
Claims Submission

WHEN CLAIMS SHOULD BE FILED

Benefits are based on the Plan's provisions at the time the charges are incurred. Charges are considered incurred when treatment or care is given or a procedure performed. Claims should be filed with the Claims Supervisor within 90 days of the date charges for the service were incurred unless:

(1) it's not reasonably possible to submit the claim in that time; and
(2) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

CLAIMS REVIEW PROCEDURE

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

(1) Request from the Plan Administrator a review of the eligibility status for any claim denied in whole or in part.
(2) Request from the Plan Administrator a review of any claim payment. Such request must include: the name of the Employee, his or her social security number, the name of the patient and the Group Identification Number, if any.
(3) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

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

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

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

Your Health Care Plan gives you broad protection to help meet the costs of most illnesses and injuries.

In this Benefit Summary Supplement you'll find the important features of your group's Health Care Plan provided by the County of Passaic through Insurance Design Administrators (IDA), utilizing a Preferred Provider Organization.

You should read this Benefit Summary Supplement carefully so that you know the health care benefits available to you and your family.

This Benefit Summary Supplement is an addition to your Health Care Benefit Booklet which you have received previously.

PASSAIC COUNTY HEALTH BENEFITS PROGRAM

BENEFIT SUMMARY SUPPLEMENT

Passaic $200 CC

INSURANCE DESIGN ADMINISTRATORS
P.O. Box 875, Oakland, NJ 07436
800/ 446-9972 Fax: 337-5342

Dental Benefits Plan
PREMIER

County of Passaic

Group No. 3318

DELTA DENTAL

Delta Dental Plan of New Jersey

1/94

America's Dental Plan Specialist

ABOUT THIS BROCHURE . . .

This is not a summary plan description designed to meet the requirements of ERISA. This brochure contains a general description of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract with Delta Dental Plan of New Jersey, Inc.

HISTORY OF DELTA DENTAL

Delta Dental Plan of New Jersey, Inc. is a not-for-profit service corporation organized in 1969. During the past years, Delta has enjoyed a vigorous response from both the dental profession and the public. Delta was created by the dental profession, and now has more than 4,400 dentists, a clear majority of New Jersey's active licensed dentists, as participating members.

Many New Jersey residents from the industrial, commercial, governmental, and educational sectors are covered under Delta dental care programs.

The support of the dental profession, together with the Delta method of administration, provides the best dental care programs to the greatest number of persons in New Jersey. Delta Dental Plan of New Jersey, Inc. is a member of Delta Dental Plans Association, the nationwide association of not-for-profit dental plans.

FREE CHOICE OF DENTIST

You may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta will make payment directly to the subscriber. ***Maximum benefit can be derived by utilizing the services of a participating dentist.***

USUAL, CUSTOMARY and REASONABLE FEES

Payment for benefits under your usual, customary and reasonable fee program is based upon the prefiled fees of the participating dentist.

An important concept of Delta administration is to review:

a. the fees charged by the participating dentist, ensuring that they do not exceed usual, customary and reasonable fees,

b. the dental services to be provided, thus promoting a quality of dental care consistent with prevailing standards of dental practice.

DESCRIPTION OF COVERED SERVICES

Delta Dental Care Programs cover the following services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practice:

I. PREVENTIVE & DIAGNOSTIC SERVICES

Diagnostic- Procedures such as examinations and x-rays to assist the dentist in evaluating the existing conditions to determine the required dental treatment. Examinations are allowable twice in a twelve (12) month period.

Preventive- Procedures to assist in preventing oral disease including: prophylaxis twice in a twelve (12) month period.

II. REMAINING BASIC SERVICES

Oral Surgery- Procedures for extractions and other oral surgery including pre - and post operative care. General anesthesia when administered by a dentist in conjunction with oral surgery performed by a dentist.

Restorative - Procedures for treatment of carious lesions using amalgam, composite, porcelain or plastic restorations.

Endodontics- Procedures for pulpal therapy and root canal filling.

Periodontics- Procedures for treatment of the tissues supporting the teeth.

Emergency Care- Necessary palliative treatment for minor dental pain.

III. CROWNS, INLAYS & GOLD RESTORATIONS

Crowns, inlays and gold restorations will be provided when teeth cannot be restored with the above materials.

IV. PROSTHODONTIC BENEFITS

Procedures for construction of bridges, partial and complete dentures and repair of existing prosthetic appliances.

WHO IS ELIGIBLE?

All employees eligible for this dental care program will be covered from the first day of the month following 2 months of continuous full-time employment (minimum of 20 hours per week).

Dependents of employees are not eligible for benefits as described.

WHEN DOES COVERAGE TERMINATE?

Coverage for employees shall cease on:

1) Termination of employee's employment
2) Death of employee

CONTINUATION OF COVERAGE

Under Federal Regulations, an employee has the right to continue dental coverage if certain qualifying events are met.

Contact your employer for additional details. The individual continuing coverage shall be responsible for payment of the required premiums.

BENEFITS

(Percentage of Delta's Allowable Charges)

Preventive & Diagnostic Services	50%
Remaining Basic Services	50%
Crowns	50%
Prosthodontic Services	50%

DEDUCTIBLE

Deductible per patient for each calendar year (applies to all services)

$25

MAXIMUM

Calendar year maximum per patient for Preventive & Diagnostic, Basic, Crowns and Prosthodontic Services

$1000

SERVICES NOT COVERED

- Services for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county, or other political subdivison.
- Services with respect to congenital or developmental malformations (including TMJ), cosmetic surgery and dentistry for purely cosmetic reasons.
- Minor tooth movement
- Consultation fees
- Prescribed drugs, analgesics
- Experimental procedures
- Oral hygiene instruction
- Services performed prior to effective date of coverage
- Charges for hospitalization, including hospital visits
- Broken appointments
- Laboratory tests
- Orthodontics
- Sealants
- Fluoride treatments
- Space maintainers

LIMITATIONS

Dental services are subject to the following limitations:
(a) **X-Rays:** Complete mouth x-rays are provided only once in a three (3) year period, unless special need is shown. Supplementary bite-wing x-rays are provided not more than twice in a twelve (12) month period.
(b) **Crowns, Inlays and Gold Restorations:** Replacement will be made only after five (5) years have elapsed following any prior provision of crowns, inlays or gold restorations under any Delta program.
(c) **Prosthodontics:** Prosthodontic appliances will be replaced only after five (5) years have elapsed following any prior provision of such appliances under any Delta program. Replacement will be made of a prosthodontic appliance not provided under a Delta program only if it is unsatisfactory and cannot be made satisfactory.

OPTIONAL SERVICES

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, Delta will pay the applicable percentage of the lesser fee. The patient must pay the entire remainder of the dentist's fee.
(1) **Crowns, Inlays and Gold Restorations** will be provided only when teeth cannot be restored adequately by using amalgam, porcelain, plastic or composite restorations.
(2) **Dentures:** Delta will provide a standard cast chrome or acrylic denture. If, in the construction of the denture, the patient and the dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, Delta will allow an appropriate amount for the standard denture toward such treatment, and the patient must bear the difference in cost.
(3) **Occlusions:** Delta will allow the cost of restorations required to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the patient. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth.
(4) **Restorations:** Composite restorations will be allowed on anterior teeth only. An allowance for amalgam restorations will be made on posterior teeth.

Delta shall not be obligated to make payment for treatment plans submitted more than one year after the date of rendition of the service.

METHOD OF PAYMENT

Delta's allowable charge for each procedure will be as follows:

A) **Delta's participating dentists** will be paid based upon the least of:

1) The Dentist's charged fee,
2) The Dentist's filed fee with Delta,
3) Delta's allowance for usual, customary and reasonable fees.

(When services are performed by participating dentists, payment is made to the **Dentist.**)

B) **Non-participating dentists** will be paid based upon the lesser of:

1) The Dentist's charged fee,
2) Delta's allowance for the prevailing fee.

(When services are performed by non-participating dentists, payment is made to the **subscriber.**)

C) **Out-of-state dentists** will be paid based upon the lesser of:

1) The Dentist's charged fee,
2) Delta's allowance for usual, customary and reasonable fees.

(When services are performed by out-of-state dentists, payment is made to the **subscriber.**)

HOW TO USE YOUR PROGRAM

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists.

During your FIRST appointment, tell your dentist that you are covered under this Delta Dental Program. Give him/her your Group's name, its Delta Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

Your dentist will perform an examination and submit a predetermination form to Delta, if necessary, to determine how much of the charge will be your responsibility. Before treatment is started be sure you discuss with your dentist the total amount of his/her fee.

COORDINATION OF BENEFITS

In order to avoid duplication of payment for the same services, the benefits of the dental program are coordinated with other plans which are not purchased by the employee and which provide dental benefits. Generally, if you are covered by more than one plan, your expenses will be shared between the plans, up to the full amount of the allowable charges.

CLAIMS AND APPEAL PROCEDURE

Delta will notify you if any services are denied, in whole or in part, stating the reason(s) for the denial on a copy of the Notification of Payment which will be sent to you. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to Delta Dental Plan of New Jersey, Inc., Benefit Services Department, 959 Route 46, Parsippany, N.J. 07054. You must state the reason(s) you believe Delta should reconsider its determination of benefits. Before making a formal written request for review, you are encouraged to discuss your claim with your plan administrator.

Delta shall make a full and fair review of your request for revaluation and may require additional documents as it deems necessary or desirable in making such a review. Certain requests may be referred to one of Delta's regional consultants or to a Delta review committee. Unless referral to a review committee is required or other unusual circumstances arise, you should receive a decision on your request for review, in writing, within 30 days but no longer than 120 days after Delta receives your request.

DELTA DENTAL

Delta Dental Plan of New Jersey
959 Route 46 • P.O. Box 222
Parsippany, New Jersey 07054
Claim Inquiries: NJ (800) 452-9310
Out-of-State (800) 346-5377

The individual named hereon is enrolled in the dental program of the group identified below. This card is for identification purposes only and is not a guarantee of coverage. For information concerning benefits, you may contact Delta at the above address.

3318

NAME_____ GROUP NO._____

SOC. SEC. NO._____

FLAGSHIP
HEALTH SYSTEMS, INC.

FLAGSHIP
HEALTH SYSTEMS, INC.
P.O. Box 369
Parsippany, NJ 07054
(800) 722-3524
(201) 299-2557

GROUP PREPAID DENTAL PLAN FOR:
COUNTY OF PASSAIC
GROUP NO. 3318-9011

This booklet contains a general description of the provisions of your Flagship Prepaid Dental Plan. It is, however, only a summary and not a contract. Your rights and benefits under the Plan are subject to the exact terms, conditions, and limitations of the Group Contract between Flagship Health Systems, Inc. and your employer. The Group Contract may be obtained from, or examined at, the offices of Flagship Health Systems, Inc. or your employer.

EVIDENCE OF COVERAGE

FLAGSHIP HEALTH SYSTEMS, INC., a dental plan organization, agrees to furnish prepaid dental benefits to employees and their eligible dependents, if applicable, subject to the terms and conditions of the group contract between FLAGSHIP and the employer.

I. DEFINITIONS:

A. A COVERED PERSON is an eligible employee or eligible dependent of the employee who has elected benefits under the FLAGSHIP Prepaid Dental Plan.

B. An ELIGIBLE DEPENDENT is the employee's spouse or unmarried child who is eligible for coverage under the group contract between FLAGSHIP and the employer.

C. A PLAN DENTIST is a dentist who has signed a Dental Provider Contract with FLAGSHIP to provide certain dental services for covered persons under the FLAGSHIP Prepaid Dental Plan.

D. A PLAN DENTAL SPECIALIST is a dentist who limits his practice to one or more approved specialties and has been designated by FLAGSHIP to provide certain specialty dental services to covered persons under the FLAGSHIP Prepaid Dental Plan.

E. A DENTIST is a person licensed to practice dentistry at the time and in the place services are performed.

F. The EFFECTIVE DATE is the date when benefits are available to covered persons.

G. An EMPLOYER is the employer, association, or group of employers that enters into a contract with FLAGSHIP to provide prepaid dental services and benefits to its employees.

H. The CONTRACT TERM is the period of 12 months commencing on the effective date of the group contract and ending on the last day of the 12th succeeding month and each succeeding 12 month period thereafter.

Whenever, in describing or referring to any person or party, any word importing the masculine gender is used, the word shall be understood to include and to apply to females as well as to males.

II. TREATMENT PLANNING:

FLAGSHIP's objective is to assist all covered persons in obtaining and maintaining a good level of oral health. To achieve this goal, your plan dentist will carefully design a treatment plan with instructions regarding home care, specifically for you. Your treatment plan will be prioritized as follows:

1. Procedures that could have immediate effect on your overall oral health.

2. Active dental decay and periodontal problems that would not have an immediate effect on your oral health.

3. Replacement of missing teeth, not causing a gross lack of function.

Please note that individual circumstances may cause exceptions to be made to this treatment planning concept.

III. WHO IS ELIGIBLE FOR COVERAGE?:

A. EMPLOYEES who meet the following requirements are eligible for coverage under the Flagship Prepaid Dental Plan:

1. Full-time employees actively at work as defined in the group contract.

2. Employees who have completed the required waiting period and are employed on a full-time basis by the employer.

3. Employees who have enrolled in the FLAGSHIP Prepaid Dental Plan.

B. DEPENDENTS if included in the group contract, and who meet the following requirements are eligible for coverage under the Flagship Prepaid Dental Plan:

1. The spouse of a covered employee.

2. An unmarried child of a covered employee as defined in the group contract.

3. An unmarried child of a covered employee who is incapable of self-support because of physical or mental incapacity that commenced prior to reaching the limiting age as defined in the group contract (A physician's certificate verifying the incapacity must be submitted to FLAGSHIP following attainment of the limiting age.)

4. Legally adopted children, stepchildren and foster children who depend upon the employee for support and maintenance.

IV. WHEN COVERAGE BEGINS:

A. An EMPLOYEE'S coverage begins on the first day of the month after he becomes eligible, provided that he is actively at work and has signed a Flagship enrollment form. Otherwise, his coverage begins on the first day of the month after he returns to active work and has signed a FLAGSHIP enrollment form.

B. A DEPENDENT'S coverage begins on the same day the employee's coverage begins, provided he is an eligible dependent of the employee on that date. Otherwise, the dependent's coverage begins on the date he becomes an eligible dependent of the employee.

SPECIAL NOTE FOR CONTRIBUTORY PLANS:

If the employee is required to contribute to the plan and he fails to enroll within (31) thirty-one days from his eligibility date, the employee and his dependents may not become eligible for another twelve (12) months.

V. WHEN COVERAGE TERMINATES:

A. An EMPLOYEE'S coverage terminates:

1. When the group contract between FLAGSHIP and the employer terminates.

2. On the last day of the month in which the employee dies or terminates his employment with the employer.

3. On the last day of the month in which the employee fails to pay any required contribution under the FLAGSHIP Prepaid Dental Plan.

B. A DEPENDENT'S coverage terminates:

1. When the group contract between FLAGSHIP and the employer terminates.

2. On the day the employee's coverage terminates.

3. On the last day of the month in which the dependent ceases to be an eligible dependent of the employee.

VI. BENEFITS:

The FLAGSHIP Prepaid Dental Plan provides all reasonable and customary care as listed in the "Schedule of Benefits," if care is provided by your Plan Dentist or a Plan Dental Specialist referred by your Plan Dentist.

You must select your Plan Dentist and a second and third choice from the list of Plan Dentists provided by FLAGSHIP at the time your coverage commences. Both you and your dependents must be treated by the same Plan Dentist.

You may change your Plan Dentist on the first day of a new "Contract Term" between your employer and FLAGSHIP by giving at least thirty (30) days prior written notice to FLAGSHIP via a form provided by FLAGSHIP. You may otherwise change your Plan Dentist, with FLAGSHIP's approval, on the first day of a contract month by giving at least thirty (30) days prior written notice, which includes an explanation of the reason for the requested change, to FLAGSHIP.

VII. SPECIALTY SERVICES:

FLAGSHIP will provide each of the specialty services listed in the "Schedule of Benefits and Copayments" section.

These services, which include periodontics (treatment of diseased gums and bone), endodontics and oral surgery procedures, must be performed by a Plan Dental Specialist. REFERRALS WILL BE MADE ONLY BY A PLAN DENTIST UPON WRITTEN APPROVAL BY FLAGSHIP.

If you are referred to a Plan Dental Specialist, you will only be responsible for the copayment, if any, listed in the "Schedule of Benefits and Copayments" section.

VIII. SCHEDULE OF BENEFITS AND COPAYMENTS:

Subject to the limitations, exclusions and member copayments set forth herein the following services shall be performed as needed and deemed necessary by the Plan Dentist.

1. **PRIMARY BENEFITS** to be performed by the selected Plan Dentist:

	PLAN H MEMBER PAYS
VISITS AND DIAGNOSTIC	
Oral examination/Office visit	N/C
Emergency treatment, palliative	N/C
Specialist consultation	N/C
Pulp tests	N/C
PROPHYLAXIS AND FLUORIDE TREATMENTS	
Prophylaxis - 2 treatments per any 12 month period	N/C
Topical Fluoride - to age 19 only	N/C
X-RAYS	
Full mouth x-rays or Panorex - every 3 years	N/C
Single x-ray	N/C
Each additional x-ray - up to and including 13 films	N/C
Bite-wing x-rays - not more than 1 series of 4 films in any six month period	N/C
Intra-oral, occlusal view, upper or lower jaw	N/C
ORAL SURGERY	
Extractions (uncomplicated) - local anesthetic	11
Surgical extractions	22
Post operative visits (sutures)	N/C
Local anesthetics	N/C
Removal of tooth (soft tissue)	45
Removal of tooth (partially bony)	60
Removal of tooth (completely bony)	65
PERIODONTICS	
Emergency treatment (gum abscess, acute gum inflammation, etc.)	N/C
Subgingival curettage, per quadrant	30
Soft tissue surgery, per quadrant	90
Soft tissue surgery, per tooth (if fewer than 6 teeth)	30
Scaling and Root Planing (entire mouth)	40
Scaling and Root Planing (per quadrant)	35
Preventive Periodontal Procedures	30
Osseous Surgery (per quadrant)	210
ENDODONTICS	
Root Amputation	70
Pulp capping	12
Pulpotomy	30
Vital Pulpotomy	30
Temporary filling	85
Single root canal	125
Bi-root canal	150
Tri-root canal	200
Apicoectomy and filling canal	115
Apicoectomy - separate appointment	100

RESTORATIVE	PLAN II MEMBER PAYS
Silver Restorations-Primary Teeth	
Cavities involving one tooth surface	11
Cavities involving two tooth surfaces	11
Cavities involving three or more tooth surfaces	11
Silver Restorations-Permanent Teeth	
Cavities involving one tooth surfaces	12
Cavities involving two tooth surfaces	12
Cavities involving three or more tooth surfaces	12
Acrylic, Plastic Restorations	
Silicate cement filling	10
Acrylic or plastic filling	12
Crowns (Caps)	
Acrylic	75
Acrylic with metal	230
Porcelain	220
Porcelain with metal	240
Full metal crown	240
Gold onlay or 3/4 crown	230
Stainless steel (primary)	50
Stainless steel (permanent)	50
Removable acrylic space maintainer	N/C
Fixed Spacer, band type	N/C
PROSTHETICS (includes Fixed Bridges)	
Artificial Tooth Replacement	
Tru-pontic type	240
Porcelain to metal	240
Plastic processed to gold	230
Dentures	
Complete upper denture	250
Complete lower denture	270
Partial upper/lower (each)	270
Denture and partial adjustments	N/C
Denture and partial repairs	20
Adding teeth to existing partial or denture	30
Office reline	55
Laboratory reline	75

	MEMBER PAYS
Recementation	
Inlay	N/C
Crown	N/C
Bridge	N/C
Other Procedures	
Failure to cancel appointment (24 hours prior notification)	25
Emergency visit after normal visiting hours	25

2. **SPECIALTY SERVICES** to be performed by Plan Dental Specialist *only if approved in advance by FLAGSHIP after referral by a Plan Dentist:*

PERIODONTICS	
Periodontal scaling (entire mouth)	125
Bone surgery	210
Bone graft	100
Bone grafts - multiple sites	110
Pedicle soft tissue grafts	115
Free soft tissue grafts	120
Periodontal scaling (per quadrant)	35
ORAL SURGERY	
Impaction - full bony	65
Root recovery	25
Closure of oral fistula	60
Surgical exposure of impacted or unerupted tooth for ortho reasons	55
Surgical exposure of impacted or unerupted tooth	35
Biopsy of oral tissue - hard	30
Biopsy of oral tissue - soft	30
Plastic Surgery, per arch - uncomplicated	40
Plastic Surgery, per arch - complicated	80
Excision of tumors - benign - lesion diameter up to 1.25 cm	35
Excision of tumors - benign - lesion diameter over 1.25 cm	60
Excision of tumors - malignant - lesion diameter up to 1.25 cm	50
Excision of tumors - malignant - lesion diameter over 1.25 cm	50
REMOVAL OF CYSTS AND NEOPLASM	
Removal of odontogenic cyst or tumor up to 1.25 cm in diameter	35
Removal of odontogenic cyst or tumor over 1.25 cm in diameter	60
Removal of nonodontogenic cyst or tumor up to 1.25 cm in diameter	35
Removal of nonodontogenic cyst or tumor over 1.25 cm in diameter	60
Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy	12

	PLAN H MEMBER PAYS
EXCISION OF BONE TISSUE	
Removal of overgrowth of bone - upper or lower	55
Partial ostectomy (guttering or saucerization)	130
Radical removal of mandible with bone graft	410
SURGICAL INCISION	
Incision and drainage of abscess - intraoral	15
Incision and drainage of abscess - extraoral	20
Removal of foreign body, skin, or subcutaneous aveolar tissue	15
Removal of reaction-producing foreign bodies - musculoskeletal system	40
Removal of dead bone	30
Maxillary sinusotomy for removal of tooth fragment or foreign body	30
OTHER REPAIRS	
Frenulectomy - separate procedure (frenectomy or frenotomy)	35
Excision of hyperplastic tissue (per arch)	40
Removal of stone in salivary gland	30
Replacement of salivary duct	50
General Anesthetic	15
ENDODONTICS	
Molar root canal filling	200
Removal of portion of root (separate procedure) - first root	100
Removal of portion of root (separate procedure) each additional root	85
Removal of portion of root (in conjunction with endo per root)	115
Retrograde filling	40
Separation of roots of tooth	80
Root amputation	80

OUT-OF-AREA EMERGENCY CARE

Flagship will reimburse actual charges up to $50.00 per covered person when receiving emergency care while temporarily more than 35 miles from the Attending Flagship Dental Office.

IX. LIMITATION OF BENEFITS:

The benefits, as previously outlined, are subject to the following limitations:

A. Cleanings limited to two (2) treatments in any twelve (12) consecutive months.

B. Full upper and/or lower dentures are not to be installed or replaced more than once in any five (5) year period. Replacement of an existing denture or bridge will only be provided by FLAGSHIP if it is unsatisfactory and cannot be made satisfactory.

C. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

D. Fixed bridges will be authorized ONLY when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment. The patient would then be responsible for the difference between the cost of a partial and a fixed bridge.

E. Denture relines limited to one (1) during any twelve (12) consecutive months.

F. Periodontal treatments limited to five (5) during any twelve (12) consecutive months.

G. Bite-wing x-rays limited to not more than one (1) series of four (4) films in any six (6) month period.

H. Full mouth x-rays limited to one (1) set every thirty-six (36) consecutive months.

X. EXCLUSION OF BENEFITS:

The following services are not covered by the FLAGSHIP Prepaid Dental Plan:

A. Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability Laws; services which are provided by any Federal or State or Provincial government agency; or services which are provided without cost to the Covered Person by any municipality, county or political subdivision or community agency.

B. Services rendered or items furnished for any conditions, disease, ailment or injury occurring while the Covered Person is on active duty during military service, or for services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.

C. Surgical procedures to correct congenital malformations or developmental malformations, and procedures, appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occulusion or restore tooth structure lost by attrition.

D. Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.

E. Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.

F. All other services not specifically included in the Group Contract between FLAGSHIP and the employer.

G. Hospital charges of any kind.

H. Major surgery of fractures and dislocations.

I. Loss or theft of dentures or bridgework.

J. Lost, stolen or broken orthodontic appliances.

K. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage under the FLAGSHIP Prepaid Dental Plan.

L. Dental expenses incurred in connection with any dental procedure started prior to a Covered Person's eligibility under the FLAGSHIP Prepaid Dental Plan. (Example: teeth prepped for crowns, root canals in progress).

M. Malignancies.

N. Any dental procedure unable to be performed in the dental office because of the general health and physical limits of the patient.

O. Full mouth rehabilitation.

P. Services or treatment, which in the opinion of the Plan Dentist, are not necessary for the patient's dental health.

GENERAL INFORMATION

FLAGSHIP is founded on the principles of delivering quality dental care and preventing dental problems before they start. Dental services are provided solely at or through FLAGSHIP Plan Dental offices. If any services are provided at any other dental office, the patient will be obligated to pay for these services.

A. If you have any QUESTIONS regarding services provided under the FLAGSHIP Prepaid Dental Plan, you should telephone FLAGSHIP'S Benefit Services Department at:

(800) 722-3524
(201) 299-2557

Or write:

FLAGSHIP HEALTH SYSTEMS, INC.

P.O. Box 369
Parsippany, New Jersey 07054

B. When making an APPOINTMENT with a Flagship Plan Dentist, remember:

1. Advance appointments are required.

2. Identify yourself as a covered person through the FLAGSHIP Prepaid Dental Plan.

3. Your Plan Dentist will provide an appointment within ten (10) working days.

4. If you cannot keep your appointment, notify the Plan Dentist at least twenty-four (24) hours in advance, or you will be charged for a broken appointment.

C. If you have a COMPLAINT which you feel is justified,:

1. State your complaint in writing and mail it to FLAGSHIP at the address listed above in Paragraph A.

2. FLAGSHIP will answer your complaint within fifteen (15) working days after it is received.

3. Complaints may also be made by telephone, or in person, to a FLAGSHIP Benefit Services Representative. Your dental records will be reviewed and, if necessary, a dental exam will be arranged.

New Jersey Directory of Dentists

DELTACARE®

Provided by Flagship Health Systems, Inc.

A subsidiary of Delta Dental Plan of New Jersey, Inc.-
the state's leading provider of prepaid group dental benefits.

LIMITATIONS AND EXCLUSIONS OF BENEFITS

■ LIMITATIONS

The benefits, as previously outlined, are subject to the following limitations:

1. Cleanings limited to two (2) treatments in any twelve (12) consecutive months.
2. Full upper and/or lower dentures are not to be installed or replaced more than once in any five (5) year period. Replacement of an existing denture or bridge will only be provided by Flagship if it is unsatisfactory and cannot be made satisfactory.
3. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
4. Fixed bridges will be authorized ONLY when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment. The patient would then be responsible for the difference between the cost of a partial and a fixed bridge.
5. Denture relines limited to one (1) during any twelve (12) consecutive months.
6. Periodontal treatment limited to five (5) during any twelve (12) consecutive months.
7. Bite-wing x-rays limited to not more than one (1) series of four (4) films in any six (6) month period.
8. Full mouth x-rays limited to one (1) set every thirty-six (36) consecutive months.

■ EXCLUSIONS

The following services are not covered by the Flagship prepaid dental plan:

1. Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability Laws; services provided by any Federal, State or Provincial government agency; or services which are provided without cost to the covered person by any municipality, county, or political subdivision or community agency.
2. Services rendered or items furnished for any conditions, disease, ailment or injury occurring while the covered person is on active duty during military service, or for services or items provided under the laws of the United States of America or any state of the United States or any foreign country or of any political subdivision of any of the foregoing.
3. Surgical procedures to correct congenital malformations or developmental malformations, and procedures, alliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure by lost attrition.
4. Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.
5. Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.
6. All other services not specifically included in the Group Contract between Flagship and the employer.
7. Hospital charges of any kind.
8. Majory surgery of fractures and dislocations. Loss or theft of dentures or bridgework.
9. Lost, stolen or broken orthodontic appliances.
10. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage under the Flagship prepaid dental plan.
11. Dental expenses incurred in connection with any dental procedure started prior to a covered person's eligibility under the Flagship prepaid dental plan. (Example: teeth prepped for crowns, root canals in progress).
12. Malignancies.
13. Any dental procedure unable to be performed in the dental office because of the general health and physical limits of the patient.
14. Full mouth rehabilitation.
15. Services or treatment, which in the opinion of the plan dentist, are not necessary for the patient's dental health.

■ ORTHODONTIC LIMITATIONS AND EXCLUSIONS

Flagship's capitation program provides coverage for orthodontic treatment plans provided by an orthodontist that has contracted to treat DeltaCare patients.

1. Orthodontic treatment must be provided by a member of the Flagship orthodontic panel.
2. Plan benefits cover twenty-four (24) months of usual and customary orthodontic treatment.
3. The following are not benefits included: lost or broken appliances, retreatment of orthodontic cases, treatment in progress at inception of eligibility, changes in treatment necessitated by accident of any kind, surgical procedures (including extraction of teeth solely for the purpose of orthodontia) incidental to orthodontic treatment, myofunctional therapy, surgical procedures related to cleft palate, micrognathia or macrognathia, treatment related to temporo mandibular joint disturbances and/or hormonal imbalance, dispensing of drugs, general anesthetics including intravenous and inhalation sedation, dental services of any nature performed in a hospital, any dental procedure considered within the field of general dentistry such as fillings or extractions, malocclusions which are so severe or mutilated so as not to be amenable to ideal orthodontic therapy, treatment that extends beyond twenty-four (24) months from the beginning of active treatment will be subject to an office visit charge.
4. If a Covered Person does not require treatment or refuses to complete treatment, he/she will still be required to pay the orthodontist start-up costs not to exceed $350.00 for the initial examination, diagnosis, consultation, study-model impressions, and the retention phase of treatment.
5. The European method of orthodontia - activator appliances used in conjunction with eventual banding - is to be considered as full treatment.

COUNTY OF PASSAIC

	DELTA PREMIER	DELTACARE
Plan Design		
Preventive & Diagnostic	50%	No Charge
Remaining basic	50%	See below
Crowns	50%	See below
Prosthodontics	50%	See below
Annual Maximum	$1,000	None
Deductible	$25.00	None
Procedure Codes	**Approximate out of pocket**	
011-Initial Oral Exam	$16.00	0.00
0210-X Rays Complete	32.00	0.00
0272-2 Bitewing X Rays	8.00	0.00
1110-Adult Prophylaxis	25.00	0.00
2150-2 Surface Filling	36.00	11.00
2330-1 Surface Composite	33.00	12.00
2750-Porcelain with Gold	312.50	240.00
3310-Anterior Root Canal	170.00	125.00
4220-Gingival Curettage Quad	50.00	30.00
5110-Complete Upper Denture	350.00	250.00
6750-Abutment Crown	312.50	240.00
7110-Single Extraction	36.00	11.00

TO: EMPLOYEES OF PASSAIC COUNTY #3318-0001-9001-0011-9011

RE: DELTACARE-MANAGED DENTAL CARE OPTION

Attached is a comparison sheet explaining Delta's Dual Choice Program. Under Deltacare you select a personal dentist from the provider booklet. With Deltacare there are no claim forms to complete No Deductibles to satisfy and No yearly Maximums.

Listed below are some important points each employee should consider before enrolling with Deltacare.

1. You must complete an enrollment card and select three dentist from three separate offices. The first you select will be your plan dentist.

2. If a person is electing Deltacare they must remain in the program for one year. At the next enrollment date you may change if you desire.

3. If you are currently in the middle of treatment, please have this treatment completed before you make a switch.

4. If you need a specialist , your personnel dentist will help you choose a specialist an send a pre-authorization to Deltacare.

THIS IS AN EMPLOYEE BENEFIT ONLY

ATLANTIC

Egg Harbor Twp.
Dr. P. Musicaro
3419 Bargaintown Rd.
Egg Harbor Twp 08234
(609) 653-1268
(609) 9332

Margate
Dr. S. Millstein
8500 Ventnor Ave.
Margate 08402
(609) 822-2453
Office 7339

Pleasantville
Dr. W. Conn
1514 North Main St.
Pleasantville 08232
(609) 646-9200
Office 9073

Ventnor
Dr. B. McLaughlin
7227 Ventnor Ave.
Ventnor 08406
(609) 822-0911
Office 17072

BERGEN

Bergenfield
South Washington
Dental Assoc. PC
D[illegible]rada &
Pa[illegible]eque
375 S Washington Ave
Bergenfield 07621
(201) 439-0551
Office 99837

Dumont
Ultimate Dental P.A.
8 New Milford Ave.
Dumont 07628
(201) 384-3333
Office 99814

Fairlawn
Dr. A. Morgulis
D.D.S. PA
Dr. H. Devaris
35-08 Morlot Ave.
Fairlawn 07410
(201) 797-7476
Office 13847 (S.R)

Hackensack
Dr. F. Cherkez
520 Summit Ave.
Hackensack 07601
(201) 488-8866
(201) 8683

Dr. D. Jenne
433 Essex Street
Hackensack 07601
(201) 488-0104
Office13539 (I.S)

Midland Park
Dr D. Rosenblatt
251 Godwin Ave.
Midland Park 07432
(201) 445-2797
Office 14180

Paramus
Applied Dental
Health, PA
22 Madison Ave.
Paramus 07652
(201) 368-3688
Office 99097

Ridgefield Park
Dr. L. Thomas
288 Main Street
Ridgefield Park 07660
(201) 487-8621
Office 8933 (F)

Saddle Brook
Dental Health
Dr. R. Agresti
40 Mayhill St.
Saddle Brook 07662
(201) 843-4430
Office 99962 (S)

Woodcliff Lakes
Dr. W. Kurylo
39 Woodcliff Ave.
Woodcliff Lks. 07675
(201) 573-0430
Office 10030

Wyckoff
Dr. N. P. Akellian
374 Clinton Ave.
Wyckoff 07481
(201) 891-5424
Office 99018

BURLINGTON

Browns Mills
Browns Mills
Dental Center
Dr. A. Sadiq
55 Pemberton -
Browns Mills Road
Browns Mills 08015
(609) 893-5200
Office 99990
(C.R,P.G.S)

Marlton
Dr. A. Sadiq
9001 Greentree
Commons
Marlton 08053
(609) 596-8282
Office 13540 (In.Y)

Moorestown
Dr. R. Gross
Triangle Medical
Arts Building
702 E. Main St.
Moorestown 08057
(609) 727-4770
Office 11037

CAMDEN

Camden
Gelman Dental Assoc.
Dr. I. Gelman
639 Market St.
Camden 08102
(609) 964-0979
Office 5676 (S)

Cherry Hill
Dr. C. Donn
1940 Route 70 East
Cherry Hill 08003
(609) 424-7477
Office 12510

Dental Delivery
Systems
Dr. E. Levine
712 Haddonfield Rd.
Cherry Hill 08002
(609) 662-1155
Office 14789

Magnolia
Dr. R. Dakin
540 Fresno Drive
Magnolia 08049
(609) 784-2858
Office 7044

CAPE MAY

Cape May C. H.
Dr. W. Conn
Dogwood Dr. & Rte.9
Cape May C.H. 08210
(609) 465-3930
Office 99984

Woodbine
Woodbine Dental
Dr. J. Nathan
901 Dehirsch Ave.
Woodbine 08270
(609) 861-2784
Office 8794

CUMBERLAND

Millville
Dr. G. Shuster
210 N. Second St.
Millville 08332
(609) 825-1748
Office 6818

Vineland
Dr. M. Gorsen
1017 East Landis Ave.
Vineland 08360
(609) 692-4670
Office 8470 (S)

ESSEX

Bloomfield
Center for Dentistry
of Bloomfield
Dr. A. Varma
401 Franklin St.
Bloomfield 07003
(201) 748-0400
Office 15248 (In)

Caldwell
Dr. L. Abrevaya
16 Park Ave.
Caldwell 07006
(201) 226-0260
Office 10105

East Orange
Dr. R. Chaiklin
62 Halsted St. #201
East Orange 07018
(201) 674-3100
Office 16814

Dental Care Plus
Dr. P. Glenn
22 Sanford Street
East Orange 07018
(201) 672-0086
Office 15979 (S)

Atlantic Dental Center
Dr. A. Hall
137 Evergreen Pl.
East Orange 07018
(201) 674-1414
Office 14089 (S,P)

Dr. G. Harper
185 Central Ave.
East Orange 07018
(201) 672-2276
Office 11308

Irvington
Dental Health Assoc.
Dr. C. Lisman
2 Washington Ave.
Irvington 07111
(201) 375-0662
Office 10843 (F,S)

Dental Health Assoc.
Dr. C. Lisman
1146 Stuyvesant Ave.
Irvington 07111
(201) 399-5000
Office 99835

Dr. S. Jean-Romain
964 Sanford Ave.
Irvington 07111
(201) 374-3591
Office 18463

Center for Dentistry
Dr. G. Strathaus
1187 Clinton Ave.
Irvington 07111
(201) 375-0400
Office 15688 (S)

Dr. C. Wilson
964 Sanford Ave.
Irvington 07111
(201) 374-7100
Office 9430 (S)

Livingston
Dr. C. Perruzzi
28 East Northfield Rd.
Livingston 07039
(201) 535-6000
Office 19224

Newark
Dr. R. Agresti
500 Mt. Prospect Ave.
Newark 07104
(201) 485-1272
Office 6657 (S)

Nutley
Dr. W. Koeller
175 Franklin Ave.
Nutley 07110
(201) 667-3456
Office 14045

Dr. R. Ramer
609 Franklin Ave.
Nutley 07110
(201) 667-1887
Office 7667

West Orange
Dr. R. Fernandes
405 Northfield Ave.
Suite LL4
West Orange 07052
(201) 325-5030
Office 19713

GLOUCESTER

Glassboro
Dr. R. Lefkowitz
506 N. Delsea Drive
Glassboro 08028
(609) 881-5939
Office 14489

Bayonne
Bayonne Dental
711 Avenue C
Bayonne 07002
(201) 437-3500
Office 8423

Dr. G. Heir
718 Broadway
Bayonne 07002
(201) 339-4847
Office 9439

Guttenberg
Guttenberg Dental
Assoc., P.C.
Dr. J. Prasad
6300 Bergenline Ave.
Guttenberg 07093
(201) 861-6000
Office 99085

Jersey City
Drs. Davis, Saltzberg,
and Wenger
5 McWilliams Pl.
Jersey City 07302
(201) 963-1226
Office 8128 & 9672 &
2185 (P,S,R,Fi)

Drs. Davis, Saltzburg,
and Wenger
(St Christ Hospital)
42 Palisades Ave.
Jersey City 07306
(201) 798-5551
Office 99070 (S,R,Fi)

Dental Health Assoc.
Dr. C. Lisman
46 Bergen
Ave.,Ste.212
Jersey City 07306
(201) 946-1000
Office 99820

Dr. R. Doyle
2 Journal Square
Jersey City 07306
(201) 653-1112
Office 8516 (S)

Dr. P. Freeman, Sr. &
Dr. P. Freeman, Jr.
603 Kennedy Blvd.
Jersey City 07304
(201) 332-1664
Offices 6141 & 18082

Summit Plaza Dental
C. J. Williams
600 Kennedy Blvd.
Jersey City 07306
(201) 659-7717
Office 8190 (S, Fi)

Dr. John Lagana
Dr. John Taltavall
7816 Kennedy Blvd.
North Bergen 07047
(201) 869-5156
Office 99822

Kearny
Dr. J. Perricci
594 Kearny Ave.
Kearny 07032
(201) 991-1733
Office 17939

Union City
Dr. S. Grossman
4207 Bergenline Ave.
Union City 07087
(201) 866-7998
Office 12426 (S)

Dr. M. Valerio
524 42nd Street
Union City 07087
(201) 863-9090
Office 11566 (S)

West New York
Dr. R. Poli
6412 Park Ave.
West New York 07093
(201) 868-9007
Office 12569 (S)

HUNTERDON --

Flemington
Dr. A. Gordon
43 Church Street
Flemington 08822
(908) 782-4532
Office 6113

Whitehouse Station
Whitehouse Dental
Dr. M. Weber
US Hwy. 22E &
Rte. 523
Whitehouse Station
08889
(908) 534-4001
Office 18794

MERCER

Princeton
Montgomery Dental
Dr. B. Vohra
513 Executive Drive
Princeton 08540
(609) 683-5651
Office 19222 (Hi)

Dr. D. Tuccillo
Dr. G. Tuccillo
708 Chambers St.
Trenton 08611
(609) 394-7151
Office 6813 (S)

Dr. T. Ungrady
210 Sanhican Dr.
Trenton 08618
(609) 394-5251
Office 16521

MIDDLESEX

Edison
Clara Barton
Professional Dental
Group
Dr. V. Menza
776 Amboy Ave.
Edison 08837
(908) 738-1551
Office 13067 (S)

Iselin
Dr. S. Gordon
37 Gill Lane
Iselin 08830
(908) 283-0500
Office 11261 (G,S)

Milltown
Dr. J. Lukacs
Dr. M. Lukacs
180 N. Main Street
Milltown 08850
(908) 247-3684
Office 8726 & 9271

New Brunswick
Dr. S. Bobroy
242 Easton Ave.
New Brunswick 08901
(908) 246-0288
Office 7864

Old Bridge
Dr. Venditto
200 Perrine Rd.
Suite 222
Old Bridge 08857
(908) 727-7600
Office 16108

Perth Amboy
Dr. J. Morales
147 Market St.
Perth Amboy 08861
(908) 826-0410
Office 13533 (S)

Dr. B. Mozo
1550 Park Ave.
South Plainfield 07080
(908) 757-2222
Office10850
(Gr,F,S,I,C)

Woodbridge
Family Dental Center
1 Woodbridge Center
Woodbridge 07095
(908) 636-0600
Office 7271 (S)

MONMOUTH

Freehold
Dr. M. Saad
34 Thoreau Dr.
Freehold 07728
(908) 303-7900
Office 17552 (F,Ar,I,S)

Hazlet
Dr. E. Winograd
33 Village Court
Hazlet 07730
(908) 264-7070
Office 7639

Long Branch
Dr. A. Bressler
668 Westwood Ave.
Long Branch 07740
(908) 229-8253
Office 12194 (S)

Manasquan
Dr. J. Herbster
Brielle Hills, Unit 9B
Manasquan 08736
(908) 223-8899
Office 13910

Brielle Hills
Dental Group
Dr. V. Menza
2640 Route 70
Manasquan 08736
(908) 223-2334
Office 99947

Morganville
Dr. M. Greiner
100 Campus Dr.
Suite 202
Morganville 07751
(908) 972-2300
Office 11999

Ocean
Dr. M. Berley
1205 Rt. 35N.
Ocean 07712
(908) 531-8020
Office 13510

Gr,F,S,I,C
Dr. V. DeAngelis
804 W. Park Ave.
Bldg B Suite 2G
Ocean 07712
(908) 493-1822 (S,I)
Office 18727

Red Bank
Dr. M. Weber
326 Broad St.
Red Bank 07701
(908) 224-9339
Office 99830 (I)

Shrewsbury
Poller Dental Group
850 Broad St.
Shrewsbury 07701
(908) 741-8707
Office 99998 (S)

MORRIS

Dover
North Jersey Dental
Dr. J. DeFranco
ShopRite Plaza
411 Rte. 46 E.
Dover 07801
(201) 361-4200
Office 10829 (S)

Flanders
Rand Dental Associates
Dr. E. Rand
191 Route 206
Flanders 07836
(201) 927-8800
Office 16358

Morristown
Drs. Habibian&Haseeb
3 Elm Street
Morristown 07960
(201) 292-0001
Office 99828
(Hi, Pn, R)

Parsippany
Dr. W. Morias
415 Parsippany Rd.
Parsippany 07054
(201) 887-2298
Office 4738

Riverdale
Dr. B. Leibowitz
66 Newark Pompton
Turnpike
Riverdale 07457
(201) 835-1195
Office 9685

Brick
Dr. A. DeLuca
2024 Route 88
Brick 08724
(908) 840-1300
Office 10149

Lakewood
Dr. R. Richter
604 E. Kennedy Blvd.
Lakewood 08701
(908) 367-7171
Office 9179 (F,G)

PASSAIC

Clifton
Poller Dental Group
470 Clifton Ave.
Clifton 07011
(201) 546-6977
Office 14324 (S,P,I)

Dr. P. Smith
234 Clifton Ave.
Clifton 07011
(201) 546-4200
Office 14134

1011 Clifton Ave.
Clifton 07013
(201) 777-1772
Office 16243

Paterson
Dr. J Gross
136 Washington St.
Paterson 07505
(201) 279-2311
Office 16856

Dr. J. Mangot
426 Park Ave.
Paterson 07501
(201) 742-5541
Office 16135 (S)

Dr. D. Mayer
82 Park Ave.
Paterson 07501
(201) 881-8568
Office 13653 (S)

Paterson Dental Group
295 Broadway
Paterson 07501
(201) 742-4366
Office 99838 (S)

Park Dental
Dr. D. Gamache
275 Park Ave.
Paterson 07501
(201) 742-7275
Office 15711 (S,I)

Dr. E. Rutskin
260 Trenton Ave.
Paterson 07503
(201) 742-6158
Office 13317 (F,I,G,S)

SOMERSET

Manville
Manville Dental Group
Drs. Small and Chen
25 South Main St.
Manville 08835
(908) 722-6500
Office 99806
(C,S,R,P,I)

Warren
Dr. J Rosen
31 R Mountian Blvd.
Warren, NJ 07059
(908) 754-0442
Office 18004

SUSSEX

Hamburg
Dr. B. Eisenman
108 Route 23 So.
Hamburg 07419
(201) 827-8804
Office 15746 (Hc)

Vernon
Dr. R. Golembioski
Suite A Viking Village
5 Route 94
Vernon 07462
(201)827-0234
Office 15355 (S, P)

UNION

Kenilworth
Drs. Dehkan &
Derkasch
409 Boulevard
Kenilworth 07033
(908) 276-2225
Office 99011

Plainfield
Dr. J. Rosen
1024 Park Ave.
Plainfield, 07060
(908) 757-8390
Office 99833

Roselle
Dr. S. Jain
111 East Second A
Roselle 07203
(908) 245-7600
Office 18265

Union
Poller Dental Group
459 Chestnut Ave.
Union 07083
(908) 686-5868
Office 99082

Caring Dental Assoc
Dr. J. Prasad
1961 Morris Ave.
Union 07083
(908) 686-0302
Office 13595 (S)

WARREN

Phillipsburg
Dr. E. Lea
210 Prospect St.
Phillipsburg 08865
(908) 859-5111
Office 7435

Additional Languages Spoken

A- Armenian
Ar- Arabic
C- Chinese
F- French
Fi- Filipino
G- German
Gr- Greek
H- Hungarian
He- Hebrew
Hi- Hindi
I- Italian
In-Indian
P- Polish
Pn- Persian
Pe- Peruvian
Po- Portugese
R- Russian
S- Spanish
T- Turkish
Y- Yiddish

A managed care dental health plan provided by

Flagship Health Systems, Inc.
1639 Route 10 P.O.Box 369
Parsippany, NJ 07054

1-800-722-3524 (NJ) 1-800-848-3524 (Out of State)

1/13/9

DELTA DENTAL
Delta Dental Plan of New Jersey

Mail to:
P.O. Box 15121
Newark, NJ 07192
(201) 285-4144

DENTAL ENROLLMENT FORM

Eight Digit Group Number

- ☐ Premier _____ - _____
- ☐ Preferred _____ - 6_____
- ☐ Advantage _____ - 8_____
- ☐ DeltaCare _____ - 9_____

Name of Employer	Effective Date of Coverage

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	___/___/___	___-___-____

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
___/___/___	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐ Single ☐ Married ☐ Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		___-___-____	/ /	
Spouse*		___-___-____	/ /	
Dependent		___-___-____	/ /	☐ Yes ☐ No
Dependent		___-___-____	/ /	☐ Yes ☐ No
Dependent		___-___-____	/ /	☐ Yes ☐ No
Dependent		___-___-____	/ /	☐ Yes ☐ No

If spouse has other dental coverage, please list name and address of employer and other carrier:

If choosing DeltaCare, you must complete this section

	Choice of Dentist	Office Number	For Delta Use Only

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Health Systems of all my treatment information as a DeltaCare subscriber and the treatment information of my dependent(s).

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Subscriber Signature _____ Date _____

Delta Use Only

Entered _____

Operator # _____