AGREEMENT

Between

HANOVER TOWNSHIP
FIREMEN'S MUTUAL BENEVOLENT ASSOCIATION
LOCAL NO. 109

And

HANOVER TOWNSHIP
BOARD OF FIRE COMMISSIONERS
DISTRICT #3

MORRIS COUNTY, NEW JERSEY

FOR THE TERM COMMENCING
JANUARY 1, 2018 AND ENDING DECEMBER 31, 2020

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PREAMBLE

THIS AGREEMENT by and between the BOARD OF FIRE COMMISSIONERS OF FIRE DISTRICT #3, TOWNSHIP OF HANOVER, County of Morris, hereinafter referred to as the "DISTRICT" and/or "BOARD" and HANOVER TOWNSHIP FIREMEN'S MUTUAL BENEVOLENT ASSOCIATION, LOCAL NO. 109, hereinafter referred to as the "Union" and/or "EMPLOYEES" is designed to: maintain and promote a harmonious relationship between the Board of Fire Commissioners and its employees who are within the provisions of this Agreement, in order that a more efficient and progressive public service may be rendered; to provide for equitable and peaceful adjustment of differences that may arise; and to establish proper standards of wages, hours and other conditions of employment.

ARTICLE I
RECOGNITION AND AREAS OF NEGOTIATIONS

The Board of Fire Commissioners of Fire District No. 3, Hanover Township, recognizes HANOVER TOWNSHIP FIREMEN'S MUTUAL BENEVOLENT ASSOCIATION, LOCAL NO. 109, per Resolution #04-9-02-28, as the sole and exclusive employee representative organization for the purpose of collective negotiations concerning terms and conditions of employment, rates of pay, fringe benefits, hours of employment, procedures and the processing of grievances within the meaning of the New Jersey Employer-Employee Relations Act, *N.J.S.A.* 34:13A-5.1, *et seq.*, for a negotiating unit consisting of all full-time paid Firefighter-EMT's, and/or Firefighter-EMT-Fire Inspectors, Fire Official, Lieutenants and Captains of Fire District No. 3 in Hanover Township, now employed or hereafter, excluding volunteers.

ARTICLE II
MANAGEMENT RIGHTS AND RESPONSIBILITIES

Section 1
The Board hereby retains and reserves unto itself, without limitation, all powers, rights, authority, duties and responsibilities conferred upon and vested in it by the Laws and Constitution of the State of New Jersey and the United States including, but not limited to, generally, the foregoing rights:

Section 2
To make rules of procedure and conduct, and to use improved methods and equipment.

Section 3
To make rules and regulations as it may from time to time deem best for the purposes of maintaining order, safety and/or the effective operation of the District provided that notice of seven (7) days thereof is given to employees, to the extent same are not mandatorily negotiable.

Section 4
To hire all employees, to promote, demote, assign, layoff and to discipline and/or terminate for just cause or retain employees in the position within the District.

Section 5
Pursuant to the laws of the State of New Jersey and the United States, the exercise of the foregoing powers, rights, authority, duties or responsibilities of the District, the adoption of policies, rules, regulations and practices in the furtherance thereof, and the use of judgment and discretion in connection therewith, shall be limited only by the terms of this Agreement, and then only to the extent such terms hereof are in conformance with the Constitution and laws of the New Jersey and the United States.

ARTICLE III
SAVINGS CLAUSE

Section 1
It is understood and agreed that if any provision of this Agreement or the application of this Agreement to any persons or circumstances shall be held invalid, the remainder of this Agreement or the application of such provision to other persons or circumstances shall not be affected thereby.

Section 2
If any such provisions are so invalid the District and the Employees will meet for the purpose of negotiating changes made necessary by the applicable law.

ARTICLE IV
PENSIONS

Section 1
The District shall provide pension and retirement benefits to employees covered by this Agreement under the Police and Firemen's Retirement System and the Public Employees Retirement System, pursuant to provisions of the statutes and laws of the State of New Jersey.

ARTICLE V
CHECK OFF OF UNION DUES

Section 1
Upon receipt of proper written authorization of a member of the FMBA, the District shall deduct FMBA dues from his/her paycheck each pay period in the amount so authorized and shall remit the monies collected to the Treasurer of the FMBA each pay period.

Section 2
Any employee not wishing to belong to the certified bargaining agent will pay a service charge according to State law, pursuant to *N.J.S.A.* 34:13A-5.8.

Section 3
The FMBA agrees to indemnify and hold the District harmless from and against any and all claims arising under this provision, and shall provide the District with a copy of its demand and return system.

Section 4
If, during the life of this Agreement, there shall be any change in the rate of membership dues, the FMBA shall furnish to the District written notice thirty (30) day prior to the effective date of such change.

ARTICLE VI
GRIEVANCE PROCEDURE

Section 1 – Purpose
The purpose of this procedure is to secure, at the lowest possible level, an equitable solution to problems which may arise affecting the terms and conditions of this Agreement. The parties agree that this procedure will be kept as informal as may be appropriate.

Section 2 – Definition
The term "grievance" as used herein means any difference or dispute arising over the application or interpretation of the terms of this Agreement and may be raised by the FMBA on behalf of an individual or group of individuals, or by the District.

Section 3 – Procedure

Step 1

An aggrieved employee shall submit a grievance in writing to the Chief of the Fire Department within fourteen (14) calendar days of occurrence in question. Only those grievances submitted in writing within fourteen (14) calendar days of the occurrence shall be deemed to be timely filed.

Step 2

The Chief of the Fire Department shall submit his/her decision in writing within five (5) calendar days of the submission of the grievance to the employee.

Step 3

Within seven (7) calendar days of the decision of the Chief of the Fire Department, if the grievance is not settled to the satisfaction of both parties, the matter shall be submitted to the Board of Fire Commissioners Career Liaisons, who shall have seven (7) calendar days to submit their written decision.

Step 4

Within seven (7) calendar days of the decision of the District Career Liaisons, if the grievance is not settled to the satisfaction of both parties, the matter shall be submitted to the entire Board of Fire Commissioners. The Board of Fire Commissioners will have fourteen (14) calendar days to submit its written decision.

The aggrieved employee has a right to representation by an official of the FMBA in Steps 1, 2, 3 and 4 hereof.

Step 5

Within fourteen (14) calendar days of the transmittal of the written decision by the District, if the grievance involves a dispute over the application or interpretation of the terms of this Agreement and is not settled to the satisfaction of both parties, the FMBA or the District may present such grievance in writing within twelve (12) working days thereafter to the New Jersey Public Employment Relations Commission for arbitration. The provisions of this Agreement and the Constitution and laws of the State of New Jersey shall bind the arbitrator. Such arbitrator shall have the authority to hear and determine the grievance, and his/her decision shall be final and binding on both parties. The arbitrator's decision shall in no way alter, add to, or delete from the terms of this Agreement. He/she shall decide the dispute within thirty (30) days after the hearing has been closed, unless the parties agree to extend such time in writing. The fee and expenses of the arbitrator shall be borne equally by the parties. Only the District or the FMBA shall have the right to submit a grievance to arbitration.

Section 4 – General Provisions

a) The steps provided for herein may be waived by mutual agreement of the parties in writing.

b) If the District fails to meet and/or answer any grievance within the prescribed time limits as here before provided, such grievance may be processed to the next step.

c) If the grievant fails to present the grievance in a timely fashion to the next step, the grievance shall be deemed to be abandoned.

d) All conferences and hearings conducted under any grievance procedure shall be conducted in private by the Chief of the Fire Department, Board of Fire Commissioners, or a subcommittee thereof, and shall be limited to the parties in interest, their representatives, the witnesses and such other persons as are reasonably necessary for a fair and equitable determination.

ARTICLE VII
HOURS OF WORK

Section 1

Hours of work for employees covered by this agreement shall require being on duty for a total of eighty (80) hours per two (2) week cycle. Scheduling shall be at the discretion of the Chief of the Department or his/her designee. Any change to an employee's schedule shall be done so in writing, by the Chief of the Department, with at least ten (10) days' notice, with the exception of emergency situations. Upon an employee reaching their required eighty (80) hours, any time worked beyond the eighty (80) hours, during that two (2) week cycle, shall be paid out to the employee at one and one-half (1 ½) times their normal rate, except as otherwise set forth in this Agreement.

Any agreement between employees to swap a shift or work a shift for another employee must be returned in equal time within the same pay period or cycle and shall be for equal number of shift hours.

ARTICLE VIII
PAY DATES

Section 1

Paychecks shall be made available to employees on a twenty-six (26) week pay cycle, and include all hours worked and overtime incurred during the cycle.

Section 2

In the event the District or employee determines that there has been an error in an employee's paycheck, an underpayment or overpayment shall be corrected by the next pay period.

ARTICLE IX
OVERTIME PAY AND RESPONSE

Section 1

The parties agree the employees shall be entitled to overtime for those hours worked in excess of 80 hours in a two-week work cycle, and in those instances where the employees are required to extend the normal working day schedule in connection with the performance of duties as required by the District and/or Officer in Charge, at the rate of time and one-half, except as may otherwise set forth herein. The parties agree that the two-week work cycle constitutes a fourteen-consecutive-day "work period" for purposes of Section 7(k) of the federal Fair Labor Standards Act.

Section 2
The employees shall be compensated at the rate of time and one-half per hour for attendance at drills, schools, and job-related training needed to maintain current certification if classes are attended outside the workday schedule and are approved by the Chief of the Fire Department.

Section 3
The parties recognize and agree that under certain circumstances, employees may be called for duty prior to or after regular working hours or schedule. The employee called back to work after the completion of their shift shall be compensated at the rate of time and one-half for the hours worked and shall receive minimum two (2) hours compensation in the event of a call back. Employees who return to duty for the following responses shall be required to remain on-duty, in the firehouse or at an emergency scene for a minimum of one (1) hour beyond the dispatch time The following are examples of call backs that would be treated as call-back overtime if the employee is required to report for duty to perform these functions after the completion of the employee's assigned shift:

1. Commercial Structure Fire within Hanover Township
2. Confined Space Incident
3. Any Morris County Task Force Request (Trench, Confined Space, IDRT, etc.)
4. Mutual Aid Fire Response – Outside the Township of Hanover
5. Residential Structure Fire within Hanover Township
6. Rapid Intervention Team (RIT) Request from Mutual Aid Department(s)
7. 2nd Request for any EMS call, Including second ambulance responses
8. Third (3rd) Request / Re Alert or upgraded incident where Cedar Knolls Fire Department has been dispatched to.
9. At the discretion of the Chief of Fire Department and/or the Officer in Charge of the scene

Section 4
Any time an employee is required by the District to appear in Court or on related Fire District business, at a time other than during his regular work schedule, the employee shall be reimbursed at the rate of time and one-half. A minimum of two (2) hours compensation shall be paid for Court or related appearances.

Section 5
It is understood that employees may be directed by the Chief of Fire Department to prepare and deliver necessary and/or required training to members during off duty hours. Employees shall be compensated for such hours at a rate of time and one-half, if such hours are in excess of the employee's regular hours of work.

ARTICLE X
HOLIDAYS

Section 1
The following Holidays or the day celebrated as such will be observed with full pay:

New Year's Day
President's Day
Columbus Day
Thanksgiving Day

Good Friday
Memorial Day
Independence Day
Friday after Thanksgiving
Labor Day
Christmas Day

Section 2
Career employees shall be expected to work on any of the above-listed holidays that fall within the employee's regular work week. Commencing with the execution of this Agreement and continuing through December 31, 2018, career employees who work on an above-listed holiday shall receive additional compensation equal to one-half (1/2) of their normal hourly rate for each hour worked on the holiday; that is, they will receive their normal hourly rate plus one-half their normal hourly rate for a total hourly compensation of time and one-half for each hour worked on an above-listed holiday. Effective January 1, 2019, and thereafter, career employees who work on an above-listed holiday shall receive additional compensation equal to one and one-half (1 1/2) times their normal hourly rate for each hour worked on the holiday; that is, they will receive their normal hourly rate plus one and one-half times their normal hourly rate for a total hourly compensation of double time and one-half for each hour worked on an above-listed holiday.

In the event only a portion of the career employee's work shift falls on an above-listed holiday, the employee shall receive the additional compensation described above only for the hours that actually fall on such a holiday.

ARTICLE XI
PAID TIME OFF (PTO)

Section 1

All fulltime employees will be allocated paid time off (PTO) hours, in accordance with the schedule set forth in Section 6, below, which may be used for vacation, personal or family illness or any other personal matters that cannot be attended to outside normal hours of work. The authority for the approval of an employee's PTO is vested in the Chief of the Fire Department.

Section 2
Bereavement Leave is not considered paid time off days.

Section 3
An employee may carry over forty (40) hours of unused PTO time from any single calendar year for use in future calendar years, up to a maximum of six hundred (600) unused PTO hours.

Section 4
Upon separation from the District for reasons due to retirement, or involuntary separation due to layoff, the maximum possible amount of unused PTO that may be reimbursed to the employee will be six hundred (600) hours. In the case of employees hired after May 22, 2010, unused PTO time

may be reimbursed only upon retirement, and only up to six hundred (600) hours or amount not to exceed $15,000, whichever is lower.

Section 5
In the event of the death of an employee, his survivor, being his spouse or his legal designated beneficiary (on file), shall receive payment for unused accumulated Paid Time Off hours.

Section 6
Employees shall be entitled to Paid Time Off with pay at their regular rate of pay, in accordance with the following schedule. PTO will be credited to the employee on January 1 of each year. PTO will be calculated and credited according to the number of years that will be completed during that calendar year.

a) Employees upon completing 6 months of service – 80 Hours
b) Employees having completed 1 year through 4 years – 136 Hours
c) Employees in year 5 through 11 – 200 Hours
d) Employees in year 12 through 19 – 216 Hours
e) Employees in year 20 through retirement – 240 Hours

Section 7
An employee hired on or before May 22, 2010, may elect to receive payment for PTO over the accumulated six hundred (600) hours if this time is reached prior to retirement, not to exceed forty (40) hours per year. The Board shall be notified in writing no later than November 1st of each year. The Board shall make payment to the employee within thirty (30) days of receipt of the request.

Section 8
Whenever payment for unused PTO time is called for under this Agreement, the value of such payment shall be calculated in accordance with the following formula:

a. All PTO hours accrued as of December 31, 2017, shall be valued at the normal rate of pay that the employee was earning as of December 31, 2017.
b. All PTO hours that accrue on or after January 1, 2018, shall be valued at the normal rate of pay that the employee was earning as of January 1 of the calendar year in which the PTO hours accrued.
c. When an employee uses PTO time, PTO hours shall be utilized in descending order of dollar value; that it, the PTO hours having the highest cash-out value shall be utilized first, and the PTO hours having the lowest cash-out value shall be utilized last.

ARTICLE XII
MEDICAL AND INSURANCE PROGRAMS

Section 1
The District shall provide, at no cost subject to paragraph (e) below, to the employees and their families covered by this Agreement, hospitalization and sickness insurance as described in general terms herein. Said plans shall cover employees as well as their spouses and children;

a) The District shall provide dental insurance to all employees, equal to or better than the Blue Cross/Blue Shield policy in effect at the time this Agreement takes effect. See Attachment B for summary of benefits.

b) All existing hospital, medical and prescription benefits provided to employees and their families at time of this Agreement shall be retained and continued in full force and effect, equal to or better than the policy in effect at the time this Agreement takes effect. See Attachment B for summary of benefits. The District agrees to offer three plans to the Employees in accordance with the provisions of Chapter 78, P.L. 2011, incorporated herein by reference.

c) The District agrees to maintain the $2,000 per year, per employee reimbursement plan. The Board shall also provide a Section 125 Plan for employees in accordance with the provisions of Chapter 78, P.L. 2011, incorporated herein by reference.

d) The District shall maintain life insurance coverage equal to the plan in effect at the time this Agreement takes effect.

e) Employees shall contribute the appropriate amounts at the applicable percentage of their health insurance premiums in accordance with the provisions of Chapter 78, P.L. 2011, incorporated herein by reference.

f) The District shall provide a vision care plan to all employees covered by this agreement. See Attachment C for summary of benefits.

Section 2

A $2,500 health benefit Opt-Out provision for medical benefits coverage shall be provided to all full-time employees who elect to waive medical benefits coverage. The full-time employee shall be paid annually during the first pay week of the last month of the policy period. Employees requesting the Opt-Out benefit must complete an approved waiver form specifying that they have insurance coverage through another source. A copy of that form shall be provided by the Board. If the employee withdraws the waiver of medical benefits during the course of a policy year, the employee's Opt-Out benefit will be pro-rated accordingly, and any resulting overpayment of the Opt-Out benefit will be refunded to the Fire District. Should State law limit Opt-Out payment to a level lower than $2,500, the Opt-Out payment provided by this Section shall be reduced to the maximum payment allowable by said State law.

Section 3

In the event an employee is injured in a work-related accident, he/she shall be compensated under the Workers' Compensation Laws. The District will make up the difference between the amount the employee receives from Workers' Compensation and Disability Insurance and the employee's regular salary. During the period of time that the employee collects Workers' Compensation and Disability, the employee's PTO leave shall not be charged. In the event an employee is out for more than ten (10) days with any illness or non-work-related injury, the employee shall file with the State Disability Program.

ARTICLE XIII
LEAVES OF ABSENCE

Section 1
The District may grant a leave of absence without pay to any employee who shall become injured, ill or disabled from any cause so as to be physically unfit for duty during the period of such disability and physical unfitness for duty. Such injury, illness, or disability shall be evidenced by the certificate of a physician designated by the District to examine him/her. No such leave of absence shall exceed one (1) year commencing from the date of such injury, illness or disability.

Section 2
Employees may be granted extended leaves of absence without pay according to NJ FMLA and the U.S. Department of Labor's Family and Medical Unpaid Leave Act.

ARTICLE XIV
BEREAVEMENT LEAVE

Section 1
In the event of a death in the employee's immediate family, an employee shall be granted up to three (3) working days off with pay, for wake, funeral or memorial services. Immediate family shall be construed as meaning spouse, child, father, mother, sister or brother. For all other relatives, father-in-law, mother-in-law, grandfather, and grandmother, two (2) days leave from date of death will be granted. If there are extenuating circumstances, the Chief of the Fire Department may make adjustments if necessary.

ARTICLE XV
FMBA BUSINESS AND LEAVE

Section 1
The District hereby recognizes Hanover Township FMBA Local 109 as the sole and exclusive representative of the fulltime employees for the purpose of collective negotiating. These activities shall include the presentation of grievances relating to alleged violations of this Agreement.

Section 2
The members of the FMBA negotiating committee, not to exceed two (2) in number, shall after adequate advance notice to the Chief of Fire Department be excused from daily duty, and shall suffer no loss of regular pay for all meetings between the District and the FMBA for the purpose of negotiation of the terms of an agreement, when such meetings take place at a time during which such members are scheduled to be on duty.

Section 3
Any employee or member of the FMBA shall not be discriminated against for their acts as officials of the Union membership or activities.

Section 4
One representative of the FMBA (the President or Delegate) shall after adequate advance notice to the Chief of the Fire Department be granted time off from duty, and suffer no loss of regular pay for all meetings between the District and the FMBA for the purpose of processing grievances when such meetings take place at a time during which such FMBA representative is scheduled to be on duty.

Section 5
The President and/or Executive Delegate shall be granted leave from duty with full pay in accordance with *N.J.S.A.* 40A:14-177, for all membership and State meetings of the FMBA when such meetings take place at a time when such membership is scheduled to be on duty. The term "meetings" means the regular monthly meeting and any emergency meetings, not to exceed three (3) emergency meetings per year, provided that the President gives reasonable notice to the Chief of the Fire Department and his/her absence will not unduly affect the operation of the Department.

Section 6
The Executive Delegate or the President of the FMBA shall be granted leave from duty with full pay for the annual FMBA State Convention in accordance with State law provided that they give at least sixty (60) days advance notice to the Chief of the Fire Department of the date of the meeting and the names of attendants. Payment shall be granted only for those days the Executive Delegate or the President of the FMBA is actually scheduled for duty (maximum of 3 workdays).

ARTICLE XVI
PROMOTIONS

All promotions with the Career Division of the Fire District shall be made after careful consideration by the District. Employees being considered for the rank of Fire Official must hold a State Certification as required by *N.J.A.C.* 5:71-4.1. Any Career Division employee employed before December 31, 2014, exclusive of the Chief of Department, or Assistant Chief of Department, who is appointed to serve as the Fire Official for Fire District No. 3, and holding the position of Lieutenant, shall be compensated for the position of Fire Official at the rate of that established for the position of Captain at that time; however, it should not be construed as a promotion to the position of Captain. Any compensation will last only for the duration of the appointment as Fire Official.

ARTICLE XVII
UNIFORMS

Section 1
All employees shall be provided with all necessary uniforms, at no cost, as needed as determined by the District in its sole discretion. All station wear uniforms will meet or exceed current or newly adopted safety standards, as outlined by PEOSHA. All clothing articles, which are considered a safety hazard or in poor physical condition, will be replaced in a timely manner after review of the uniform by the Chief of Department.

Section 2
The cleaning of these items shall be the responsibility of the employee. All uniform and safety shoe purchases must be in accordance with specifications established by the District.

Section 3
The District shall continue to supply at no cost, in the judgment of the Chief of the Fire Department, all personal protective equipment as needed.

Section 4
Employee's uniform sleeve patch shall have the approved Hanover Township Fire/EMS patch on the left shoulder.

Section 5
Initial issue:

A. Three (3) pairs of pants
B. One (1) pairs of shorts
C. Two (2) long sleeve Class B shirts
D. Two (2) short sleeve Class B shirts
E. One (1) short sleeve cotton polo shirt
F. One (1) station jacket
G. One (1) belt
H. One (1) pair of steel toe station uniform boots
I. Badges (1 Shirt Badge, 1 Jacket Badge, 1 Uniform Hat Badge)
J. One (1) Dress (Class A) uniform

Yearly Issue:

A. One (1) pair of pants
B. One (1) pair of shorts
C. One (1) long sleeve Class B shirt
D. One (1) short sleeve Class B shirt
E. One (1) pair of steel toe station uniform boots

ARTICLE XVIII
PERSONNEL FILES

Section 1
There shall be one Fire District No. 3 personnel file, and the employees shall have the right to examine their files at a reasonable time with prior notice to the Chief. Employees shall have the further right to rebut any derogatory materials included in their files. No reasonable request to view a file shall be refused, except that an employee shall be limited to viewing his file during regular business hours. Any photocopies shall be made at the employee's expense. At any time a document is placed in an employee's file, a copy shall be given to the employee.

ARTICLE XIX
DISCIPLINE AND DISCHARGE

Section 1
No employee shall be disciplined or discharged without cause.

Section 2
Disciplinary action may be taken against an employee, for just cause, when it is believed that the employee is not conforming to the letter or spirit of the Board's policies and rules or to specific instructions given to him; or has acted improperly, dishonestly, immorally, illegally; or has violated any of the rules, regulations, policies and procedures.

Section 3
Depending on the seriousness of the matter, disciplinary action against employees shall be in the following forms:

Informal verbal reprimand by the Chief
Written reprimand from the Chief of the Fire Department
Suspension from duty without pay by the Board
Demotion of employee by the Board
Discharge from duty by the Board

Section 4
Where the Board of Chief of the Fire Department may impose discipline, written notice of such discipline shall be given to the employee prior to imposition of said penalty. Such notice shall contain a reasonable specification of the nature of the charge, a general description of the alleged acts and/or conduct upon which the charge is based and the nature of discipline. The name of the employee who is notified of the disciplinary action shall be transmitted to the FMBA President within seventy-two (72) hours after such notice.

The employee shall have the right to be accompanied and represented by the FMBA and/or legal counsel at a disciplinary hearing.

The employee shall have the right to be accompanied and represented by the FMBA and/or legal counsel during any questioning concerning charges which takes place prior to a hearing.

The employee and the FMBA shall be entitled to a copy of the transcript and/or the tape from the hearing upon payment.

Section 5
It will not be necessary to provide written notice if immediate disciplinary action is warranted, such as a gross violation of law. A hearing may be held to investigate the charges prior to imposition of discipline or discharge. All disciplinary procedures shall be pursuant to *N.J.S.A.* 40A:14-19.

At least seven (7) days before the hearing, the employee and the FMBA President shall be notified in writing of the charges, and the time and place of the hearing.

No tape recording of such procedure shall be made without notification to the employee.

There shall be no presumption of guilt.

The employee shall have the right to be accompanied and represented by the FMBA and/or legal counsel at a disciplinary hearing.

The employee shall have the right to be accompanied and represented by the FMBA and/or legal counsel during any questioning concerning charges which takes place prior to a hearing.

The employee and the FMBA shall be entitled to copy of the transcript and/or the tape from the hearing upon payment.

Section 6
Any written reprimand will remain in the employee's permanent file, but shall not be part of progressive discipline.

Section 7
The parties acknowledge the Drugs and Alcohol Policy contained in the District Policies and Procedures Manual as the controlling policy on the issue of drugs and alcohol in the workplace. Should the District intend to amend, modify or replace the existing Drugs and Alcohol Policy, it will first notify the FMBA and afford the FMBA the opportunity to discuss the proposed amendments, modifications or replacement. Notwithstanding the foregoing, the parties agree to engage in ongoing discussions during the term of this Agreement with respect to addressing their respective concerns and issues pertaining to the Drugs and Alcohol Policy.

ARTICLE XX
BAN ON STRIKES

Section 1
It is recognized that the need for continued and uninterrupted operation of the District is of paramount importance to the citizens of the community and there should be no interference with such operation. Adequate procedures have been provided for the equitable settlement of grievances arising out of this Agreement, and the parties hereto agree that there will not be, and that the FMBA, its officers, members, agents or principals will not engage in, encourage, sanction or suggest strikes, slowdowns, mass absenteeism or other similar action which would involve suspension of or interference with normal work performance.

Section 2
The District shall have the right to discipline or discharge any employee encouraging, suggesting, fomenting, or participating in a strike, slowdown or other such interference with normal work performance.

ARTICLE XXI
SALARY

Employees covered by this agreement shall be paid in accordance with the Salary Guide included as "Attachment B." Each Step shall commence upon the employee anniversary date of appointment or promotion.

ARTICLE XXII
DISCRIMINATION AND COERCION

There shall be no discrimination, interference or coercion by the District or by any of its agents against the FMBA or against any employee because of membership or activity in the FMBA. There shall be no discrimination or coercion by the FMBA or any of their agents against any employees covered by this Agreement because of membership or non-membership in the FMBA, nor shall the District discriminate in favor of, or assist any other labor or Fire-related organization which in any way affects the FMBA's right as certified representative for the period during which the FMBA remains the certified representative of the employees. Neither the District nor the FMBA shall discriminate against any employee because of race, creed, color, age or national origin. The District will cooperate with the FMBA with respect to all reasonable requests concerning the FMBA's responsibilities as certified representatives.

ARTICLE XXIII
SAFETY AND HEALTH

To help insure against injury on the job, the FMBA may submit proposed changes in safety regulations, including the operation of equipment, which shall be reviewed with representatives of the District. This shall in no way be considered a waiver of the District's management rights.

ARTICLE XXIV
EFFECT OF THIS AGREEMENT

In the event that any provision of the Agreement shall at any time be declared invalid by Legislative Act, or any court of competent jurisdiction, or through government regulations or decree, such decision shall no invalidate the entire Agreement, it being the express intent of the parties hereto that all other provisions not declared invalid shall remain in full force and effect. {See Article III}

ARTICLE XXV
LEGAL AID

Section 1
The District shall provide legal aid to all employees in suits or other legal proceedings against them arising from incidents in the line of duty.

ARTICLE XXVI
SENIORITY

Section 1
Seniority, for the purpose of this Agreement, is defined to mean the accumulated continuous service with Hanover Township Fire District No. 3, computed from the date of hire.

Section 2
In determining seniority within the District for the purpose of layoffs, promotions, and vacation selection, prior service with another Police or Fire Department or previous Volunteer time with the District shall not be considered in calculating seniority under this Agreement.

ARTICLE XXVII
EDUCATION AND TUITION AID REIMBURSEMENT PLAN

The Education and Tuition Aid Reimbursement Plan shall provide tuition aid reimbursement to employees who satisfactorily complete job-related college courses or educational courses which constitute credit toward either an Associates Degree or Bachelor's Degree in an Emergency Services Field of study. An employee will be eligible to receive a maximum of $600 per semester not to exceed $1,200 in any one calendar year. Prior to receipt of payment, approval of the Fire Chief must be obtained by the employee. Registration, application, laboratory and similar fees, books excluded, qualify for reimbursement. A 'C" average or above (2.0 GPA) must be achieved.

ARTICLE XXVIII
DURATION OF AGREEMENT

THIS AGREEMENT shall become effective January 1, 2018 and shall continue and remain in force and effect up to and including December 31, 2020 and shall continue from year-to-year thereafter unless written notice of desire to cancel, modify or terminate same is served by either party upon the other at least sixty (60) days prior to the date of expiration.

COMPLETENESS OF AGREEMENT

THIS AGREEMENT constitutes the entire Agreement between the parties and contains all the benefits to which the employees covered by this Agreement are entitled, notwithstanding the established past practice in existence prior to this Agreement, and incudes and settles for the term of this Agreement all the matters which were or might have been raised in all negotiations between the parties leading to the signing of this Agreement.

IN WITNESS WHEREOF, the parties have set their hands and seal this 22 day of May, 2018.

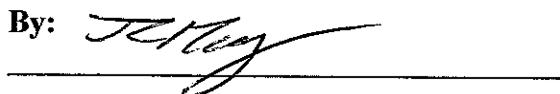
Hanover Township
Board of Fire Commissioners
Fire District No. 3

Hanover Township FMBA Local No. 109

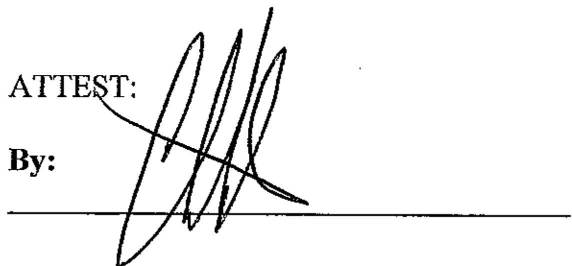
By: ____________________

By: ____________________

By:

By: 

ATTEST:

By: 

ATTACHMENT A

EXPLANATION OF BENEFITS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,200.00** Individual / **$2,400.00** Family for in-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Yes, For in-network Health/Pharmacy providers **$4,500.00** Individual /**$9,000.00** Family. Aggregate family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of in-network **providers,** see **www.HorizonBlue.com** or call **1-800-355-BLUE (2583)**	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider(You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20.00 Copayment per visit. $15.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	Not Covered.	Applies to selected PCP.
	Specialist visit	$40.00 Copayment per visit. $15.00 Copayment per visit applies only to Horizon CareOnline Deductible does not apply.	Not Covered.	Applies to non-selected PCP.
	Preventive care/screening/immunization	No Charge. Deductible does not apply.	Not Covered.	One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for Office, Independent Laboratory. $40.00 Copayment per visit for Outpatient Facility. Deductible does not apply.	Not Covered.	Molecular and genomic testing are subject to pre-service and post-service medical necessity review.
	Imaging (CT/PET scans, MRIs)	$40.00 Copayment for Outpatient Facility per visit. Deductible does not apply.	Not Covered.	Requires pre-approval.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center	Generic drugs	$10.00 Copayment/ Retail $20.00 Copayment/Mail Order.	$10.00 Copayment/ Retail $20.00 Copayment/Mail Order.	Prior authorization may be required. Covers up to a 30 day supply per copayment, up to a 90 day supply applying separate copayments (retail) and a 90 day supply (mail order).
	Preferred brand drugs	$25.00 Copayment/ Retail $50.00 Copayment/Mail Order.	$25.00 Copayment/ Retail $50.00 Copayment/Mail Order.	
	Non-preferred brand drugs	$50.00 Copayment/ Retail $100.00 Copayment/Mail Order.	$50.00 Copayment/ Retail $100.00 Copayment/Mail Order.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
www.MyPrime.com or 1-800-370-5088. View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2018/2018_NJ_3T_HealthInsuranceMarketplaceClassicDL.pdf	Specialty drugs	Covered at retail benefit in above applicable categories.	Covered at retail benefit in above applicable categories.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible for Ambulatory Surgical Center, Outpatient Facility.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	20% Coinsurance after deductible for Ambulatory Surgical Center, Outpatient Facility.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 20% Coinsurance after deductible for anesthesia.
If you need immediate medical attention	Emergency room care	20% Coinsurance after deductible and $100.00 Copayment per visit for Outpatient Hospital.	20% Coinsurance after deductible and $100.00 Copayment per visit for Outpatient Hospital.	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Emergency medical transportation	20% Coinsurance after deductible.	20% Coinsurance after deductible.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$40.00 Copayment per visit for Specialist. Deductible does not apply.	$40.00 Copayment per visit for Specialist.	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
	Physician/surgeon fees	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	20% Coinsurance after deductible for anesthesia.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	none
	Inpatient services	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
If you are pregnant	Office visits	$20.00 Copayment per visit for Office. $40.00 Copayment per visit for Specialist. Deductible does not apply.	Not Covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	none
	Childbirth/delivery facility services	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible for Outpatient Facility.	Not Covered.	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
	Habilitation services	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	
	Skilled nursing care	20% Coinsurance for Inpatient Facility after deductible.	Not Covered.	
	Durable medical equipment	50% Coinsurance. Deductible does not apply.	Not Covered.	
	Hospice services	20% Coinsurance for Inpatient Facility after deductible.	Not Covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If your child needs dental or eye care.	Children's eye exam	No Charge. Deductible does not apply.	Not Covered.	In-network routine vision exam child visit limit is 1 visit.
	Children's glasses	Amounts greater than $125.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vison. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection and $125 allowance for non-collection frames.
	Children's dental check-up	Not Covered.	Not Covered.	none

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Only covered for Members age 15 and younger)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult, Optometrist/Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (limited to artificial insemination; requires pre-approval)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $1,200.00
- Specialist *Copayment* $40.00
- Hospital (facility) *Coinsurance* 20%
- Other *Coinsurance* 0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200.00
Copayments	$760.00
Coinsurance	$1,792.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$3,812.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $1,200.00
- Specialist *Copayment* $40.00
- Hospital (facility) *Coinsurance* 20%
- Other *Coinsurance* 50%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,215.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$55.00
The total Joe would pay is	**$1,270.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $1,200.00
- Specialist *Copayment* $40.00
- Hospital (facility) *Coinsurance* 20%
- Other *Coinsurance* 50%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,079.00
Copayments	$200.00
Coinsurance	$288.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,567.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો.

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bą́ąh ílíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (اردو): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

An Independent Licensee of the
Blue Cross and Blue Shield Association.

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-355-BLUE (2583)** (TTY/TDD **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

If you are not a Horizon BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling **1-866-660-6528** (TTY/TDD **711**) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

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Blue Cross and Blue Shield Association.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500.00** Individual/**$1,000.00** Family for OMNIA Tier 1 providers. **$2,500.00**/Individual or **$5,000.00**/ Family for Tier 2 providers. OMNIA Tier 1 accumulates to Tier 2.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Yes, For Health/Pharmacy OMNIA Tier 1 providers **$3,500.00** Individual/ **$7,000.00** Family and for Tier 2 providers **$6,350.00** Individual/ **$12,700.00** Family. Aggregate family. OMNIA Tier 1 accumulates to Tier 2.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.HorizonBlue.com or call 1-800-355-BLUE(2583) for a list of network providers.	You pay the least if you use a provider in OMNIA Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10.00 Copayment per visit. Deductible does not apply.	$30.00 Copayment per visit after deductible. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	Not Covered.	none
	Specialist visit	$25.00 Copayment per visit. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	$50.00 Copayment per visit after deductible. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	Not Covered.	
	Preventive care/ screening/ immunization	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for Office, Independent Laboratory. Deductible does not apply. $20.00 Copayment for Outpatient Hospital after deductible.	No charge for Office, Independent Laboratory. Deductible does not apply. 30% Coinsurance for Outpatient Hospital, after deductible.	Not Covered.	Molecular and genomic testing are subject to pre-service and post-service medical necessity review.
	Imaging (CT/PET scans, MRIs)	$20.00 Copayment for Outpatient Hospital after deductible.	30% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	Requires pre-approval.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088. View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2018/2018_NJ_3T_HealthInsuranceMarketplaceClassicDL.pdf	Generic drugs	$10.00 Copayment/ Retail. $20.00 Copayment Mail order.	$10.00 Copayment/ Retail. $20.00 Copayment Mail order.	$10.00 Copayment/Retail. $20.00 Copayment Mail order.	Prior authorization may be required. Covers up to a 30 day supply per copayment, up to a 90 day supply applying separate copayments (retail) and a 90 day supply (mail order).
	Preferred brand drugs	40% Coinsurance Retail/Mail order.	40% Coinsurance Retail/Mail order.	40% Coinsurance Retail/Mail order.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Non-preferred brand drugs	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	
	Specialty drugs	50% Coinsurance Retail.	50% Coinsurance Retail.	50% Coinsurance Retail.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250.00 Copayment after deductible for Ambulatory Surgical Center, Outpatient Hospital.	Ambulatory Surgical Center: Not Applicable. 30% Coinsurance after deductible for Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	Deductible applies for Ambulatory Surgical Center, Outpatient Hospital.	Ambulatory Surgical Center: Not Applicable. 30% Coinsurance after deductible for Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. Deductible applies for OMNIA Tier 1 anesthesia. 30% Coinsurance after deductible for Tier 2 anesthesia.
If you need immediate medical attention	Emergency room care	Deductible and $100.00 Copayment for Outpatient Hospital.	Deductible and $100.00 Copayment for Outpatient Hospital.	Deductible and $100.00 Copayment for Outpatient Hospital.	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Deductible applies.	Deductible applies.	Deductible applies.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$25.00 Copayment per visit for Specialist. Deductible does not apply.	$50.00 Copayment per visit after deductible for Specialist.	$50.00 Copayment per visit after deductible for Specialist.	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500.00 Copayment per day for Inpatient Hospital after deductible.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval. OMNIA Tier 1 In-network separation period is limited to 90 days. $2,500.00 OMNIA Tier 1 copay maximum per admission.
	Physician/surgeon fees	Deductible applies for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Deductible applies for OMNIA Tier 1 anesthesia. 30% Coinsurance after deductible for Tier 2 anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20.00 Copayment per visit for Outpatient Hospital after deductible.	30% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	_________none_________
	Inpatient services	$500.00 Copayment per day for Inpatient Hospital after deductible.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval. OMNIA Tier 1 in-network separation period is limited to 90 days. $2,500.00 OMNIA Tier 1 copay maximum per admission.
If you are pregnant	Office visits	$10.00 Copayment per visit for Office. $25.00 Copayment per visit for Specialist. Deductible does not apply.	$30.00 Copayment per visit after deductible for Office. $50.00 Copayment per visit after deductible for Specialist.	Not Covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	Deductible applies for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	_________none_________
	Childbirth/delivery facility services	$500.00 Copayment per day for Inpatient Hospital after	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	OMNIA Tier 1 in-network separation period is limited to 90 days. $2,500.00 OMNIA Tier 1 copay maximum per

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
		deductible.			admission.
If you need help recovering or have other special health needs	Home health care	$20.00 Copayment per visit for Outpatient Facility after deductible.	Not Applicable.	Not Covered.	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	$500.00 Copayment per day for Inpatient Hospital after deductible.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval. OMNIA Tier 1 in-network separation period is limited to 90 days. $2,500.00 OMNIA Tier 1 copay maximum per admission.
	Habilitation services	$500.00 Copayment per day for Inpatient Hospital after deductible.	30% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	
	Skilled nursing care	$500.00 Copayment per day for Inpatient Facility after deductible.	Not Applicable.	Not Covered.	
	Durable medical equipment	50% Coinsurance after deductible.	Not Applicable.	Not Covered.	Requires pre-approval.
	Hospice services	$500.00 Copayment per day for Inpatient Facility after deductible.	Not Applicable.	Not Covered.	Requires pre-approval. OMNIA Tier 1 in-network separation period is limited to 90 days. $2,500.00 OMNIA Tier 1 copay maximum per admission.
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	In-network routine vision exam child visit limit is 1 visit in-network.
	Children's glasses	Amounts greater than $125.00 for non-collection frames. Deductible does not apply.	Amounts greater than $125.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vison. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection and $125 allowance for non-collection frames.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	none

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Only covered for Members age 15 and younger)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult, Optometrist/ Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (limited to artificial insemination; requires pre-approval)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

Does this plan provide Minimum Essential Coverage? Yes

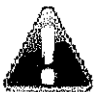
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $500.00
- Specialist *Copayment* $25.00
- Hospital (facility) *Coinsurance* 0%
- Other *Coinsurance* 0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500.00
Copayments	$985.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$1,545.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $500.00
- Specialist *Copayment* $25.00
- Hospital (facility) *Coinsurance* 0%
- Other *Coinsurance* 50%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$780.00
Coinsurance	$1,433.00
What isn't covered	
Limits or exclusions	$55.00
The total Joe would pay is	**$2,268.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $500.00
- Specialist *Copayment* $25.00
- Hospital (facility) *Coinsurance* 0%
- Other *Coinsurance* 50%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500.00
Copayments	$175.00
Coinsurance	18.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$693.00**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો.

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bą́ąh ílíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (اردو): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

An Independent Licensee of the
Blue Cross and Blue Shield Association.

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583)** (TTY/TDD **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

If you are not a Horizon BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling **1-866-660-6528** (TTY/TDD **711**) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

An Independent Licensee of the Blue Cross and Blue Shield Association.

OMNIA Gold 2018– Small Group Market

All hospitals in the Horizon Hospital Network and all Horizon Managed Care Network physicians and other health care professionals are considered in network for OMNIA Health Plan members. OMNIA Health Plan members will have lower out-of-pocket costs if they receive care from OMNIA Tier 1 hospitals and physicians. Members enrolled in this plan have no benefits for out-of-network services, except in the event of an emergency.

	OMNIA Tier 1	Tier 2
Deductible	$500 individual / $1,000 family	$2,500 individual / $5,000 family
Coinsurance	100%	70%
Maximum Out-of-Pocket	$3,500 individual/$7,000 family	$6,350 individual/$12,700 family
Primary Care Physician*	$10 copayment	$30 copayment after ded.
Specialist	$25 copayment	$50 copayment after ded.
Inpatient Hospital	$500 copay/day after ded.	70% coinsurance after ded.
Emergency Room (ER)	$100 copayment after ded.	$100 copayment after ded.
Outpatient Surgery Copayment (Facility)	$250 copayment	70% coinsurance after ded.
Laboratory Services – (non hospital)	$0 copayment	70% coinsurance after ded.
Radiology Services – (non hospital)	$0 copayment	70% coinsurance after ded.
Imaging (CT/PET scans, MRIs) –	$20 copayment after ded.	70% coinsurance after ded.
Urgent Care	$25 copayment	$50 copayment after ded.
Behavioral Health and Substance Abuse Outpatient (Facility)	$20 after ded.	70% coinsurance after ded.
Behavioral Health and Substance Abuse Inpatient	$500 copay/day after ded.	70% coinsurance after ded.
Home Health Care	$20 copayment	N / A
Skilled Nursing Care	$500 copay/day after ded.	N / A
Durable Medical Equipment (DME)	50% coinsurance	N / A
Hospice	$20 copayment	N / A
Pharmacy	Generics: $10 copayment Preferred Brands: 60% coinsurance Non-Preferred Brands: 50% coinsurance	Generics: $10 copayment Preferred Brands: 60% coinsurance Non-Preferred Brands: 50% coinsurance

HOSPITAL NETWORK FINDER

This listing of OMNIA Health Plan Tier 1 and Tier 2 hospitals is complete as of January 2018. The list is subject to change, so always verify hospital network participation status prior to making your selection. Check for the most current information by:

- Using the online Doctor & Hospital Finder located on our website at **HorizonBlue.com/doctorfinder**
- Contacting the physician, health care professional or department directly
- Calling the Customer Service telephone number listed on your ID card

Select the OMNIA Health Plan Tier 1 or Tier 2 hospital that's right for you to maximize your coverage benefit.

Hospital Name	County	Tier 1	Tier 2
AtlantiCare Regional Medical Center	Atlantic	✓	
Shore Medical Center	Atlantic		✓
Englewood Hospital	Bergen	✓	
Hackensack UMC at Pascack Valley (Hackensack Meridian Health)	Bergen	✓	
Hackensack University Medical Center (Hackensack Meridian Health)	Bergen	✓	
Holy Name Hospital	Bergen		✓
The Valley Hospital	Bergen		✓
Doylestown Hospital	Bucks		✓
St. Luke's Hospital - Quakertown	Bucks		✓
Deborah Heart and Lung Center	Burlington		✓
Lourdes Medical Center of Burlington County	Burlington		✓
Virtua – Memorial Hospital of Burlington County	Burlington		✓
Cooper Hospital University Medical Center	Camden	✓	
Kennedy Memorial Hospital	Camden		✓
Our Lady of Lourdes Medical Center	Camden		✓
Virtua - West Jersey Hospital System	Camden		✓
Cape Regional Medical Center	Cape May	✓	
Inspira Medical Center – Vineland	Cumberland	✓	

HOSPITAL NETWORK FINDER

Hospital Name	County	Tier 1	Tier 2
Delaware County Memorial Hospital	Delaware, PA		✓
Clara Maass Medical Center (RWJBarnabas Health)	Essex	✓	
East Orange General Hospital	Essex		✓
Hackensack UMC at Mountainside (Hackensack Meridian Health)	Essex	✓	
Newark Beth Israel Medical Center (RWJBarnabas Health)	Essex	✓	
St. Barnabas Medical Center (RWJBarnabas Health)	Essex	✓	
St. Michael's Medical Center	Essex		✓
University Hospital	Essex		✓
Inspira Medical Center – Woodbury	Gloucester	✓	
Bayonne Medical Center (CarePoint Health)	Hudson		✓
Christ Hospital (CarePoint Health)	Hudson		✓
Hackensack UMC Palisades (Hackensack Meridian Health)	Hudson	✓	
Hoboken University Medical Center (CarePoint Health)	Hudson		✓
Jersey City Medical Center (RWJBarnabas Health)	Hudson	✓	
Meadowlands Hospital Medical Center	Hudson		✓
Hunterdon Medical Center	Hunterdon	✓	
Capital Health System – Fuld	Mercer	✓	
Capital Health System – Regional/Hopewell	Mercer	✓	
Robert Wood Johnson – Hamilton (RWJBarnabas Health)	Mercer	✓	
St. Francis Medical Center	Mercer		✓
JFK Medical Center	Middlesex		✓
University Medical Center of Princeton at Plainsboro	Middlesex		✓
Raritan Bay Regional Medical Center (Hackensack Meridian Health)	Middlesex	✓	
Robert Wood Johnson - New Brunswick (RWJBarnabas Health)	Middlesex	✓	
St. Peter's University Hospital	Middlesex		✓

HOSPITAL NETWORK FINDER

Hospital Name	County	Tier 1	Tier 2
Bayshore Community Hospital (Hackensack Meridian Health)	Monmouth	✓	
CentraState Medical Center	Monmouth		✓
Jersey Shore Medical Center (Hackensack Meridian Health)	Monmouth	✓	
Monmouth Medical Center (RWJBarnabas Health)	Monmouth	✓	
Riverview Medical Center (Hackensack Meridian Health)	Monmouth	✓	
St. Luke's Hospital – Monroe	Monroe		✓
Chilton Medical Center (Atlantic Health System)	Morris	✓	
Morristown Medical Center (Atlantic Health System)	Morris	✓	
St. Clare's Denville/Dover	Morris		✓
AI duPont Hospital for Children	New Castle		✓
St. Luke's Hospital – Anderson	Northhampton		✓
St. Luke's Hospital – Bethlehem	Northhampton		✓
Community Medical Center (RWJBarnabas Health)	Ocean	✓	
Monmouth Medical Center Southern Campus (RWJBarnabas Health)	Ocean	✓	
Ocean Medical Center (Hackensack Meridian Health)	Ocean	✓	
Southern Ocean Medical Center (Hackensack Meridian Health)	Ocean	✓	
St. Joseph's Hospital and Medical Center	Passaic	✓	
St. Mary's – Passaic	Passaic		✓
Children's Hospital of Philadelphia	Philadelphia		✓
Crozer-Chester Medical Center	Philadelphia		✓
Fox Chase Cancer Center	Philadelphia		✓
Hahnemann University Hospital	Philadelphia		✓
Hospital of the University of Pennsylvania (UPHS)	Philadelphia		✓
Jeanes Hospital	Philadelphia		✓
Pennsylvania Hospital (UPHS)	Philadelphia		✓

Horizon. | OMNIA HEALTH PLANS

HOSPITAL NETWORK FINDER

Hospital Name	County	Tier 1	Tier 2
Presbyterian Hospital (UPHS)	Philadelphia		✓
Rothman Orthopaedic Specialty Hospital	Philadelphia		✓
St. Christopher's Hospital for Children	Philadelphia		✓
Temple University Hospital	Philadelphia		✓
Thomas Jefferson University and Methodist Division	Philadelphia		✓
Inspira Medical Center – Elmer	Salem	✓	
Memorial Hospital of Salem County	Salem		✓
Robert Wood Johnson – Somerset (RWJBarnabas Health)	Somerset	✓	
Newton Medical Center (Atlantic Health System)	Sussex	✓	
Overlook Medical Center (Atlantic Health System)	Union	✓	
Robert Wood Johnson – Rahway (RWJBarnabas Health)	Union	✓	
Trinitas Regional Medical Center	Union		✓
Hackettstown Community Hospital (Atlantic Health System)	Warren	✓	
St. Luke's – Warren	Warren		✓

OMNIA Health Plan members enjoy lower premiums, lower deductibles, lower copayments and lower out-of-pocket costs with OMNIA Tier 1 doctors, hospitals, and other health care professionals, including the OMNIA Health Alliance. Members also have the flexibility to visit any Tier 2 health care professional in our broad Managed Care Network for a higher out-of-pocket cost.

OMNIA Health Plan members can receive obstetrics services at any hospital in Burlington and Mercer counties at an OMNIA Tier 1 level of benefits as a benefit exception, even if the hospital is listed as Tier 2.

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The Horizon® name and symbols are registered marks and OMNIASM is a service mark of Horizon Blue Cross Blue Shield of New Jersey.
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Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Spanish (Español): Para ayuda en español, llame al 1-866-660-6528. Chinese (中文)：如需中文協助，請致電 1-866-660-6528.

C101_201801

Board of Fire Commissioners, Dist #3
Group Health/Dental renewals 4-1-18

- If all 5 current members renewed on current Horizon Gold EPO plan, the overall annual medical cost would have gone from $56,358 to $66,253 + incurred costs through Health Reimbursement Account (HRA) by Gente. **Increase of $9,895.**

- By researching members' key physicians and introducing new OMNIA GOLD plan as a voluntary alternative, 3 of current members will be switching to this lower cost option eff 4/1/18. This will bring the annual medical cost back down to $57,396. **Increase of $1,038.**

- The GOLD renewal plan will continue to feature an HRA to fulfill contractual benefit obligations. HRA will cover member's out of pocket deductible and coinsurance expenses AFTER members incur $1,000/2000 deductible (sing/fam). In addition, members on GOLD plan are entitled to reimbursement for office copays as follows: Primary visits ($5/visit) and specialist copays ($10/visit).

- Members who select the OMNIA Gold plan will incur lower plan premiums and thus lower employee payroll deductions. By utilizing a participating network of OMNIA Tier 1 providers, members will also enjoy lower out of pocket expenses. Tier 2 providers are also available for additional out of pocket exposure.

- All plan members in OMNIA will NOT have access to additional HRA benefits. The OMNIA GOLD plan of benefits will be stand-alone.

- Members can switch plans only at open enrollment or with any life qualifying event through the year.

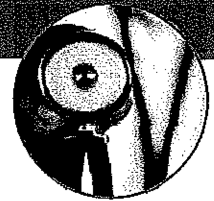
- Effective 4/1/18, an optional Flexible Spending Account will also be offered to plan members. Administration of FSA will also be through Gente, for no additional cost for administration. Members can set aside pre-tax dollars up to $2,500/year for eligible non reimbursed medical expenses in a "use it or lose it" fashion according to IRS Section 125 guidelines.

- Effective, 4/1/18, the Dental plan will be moving to Oxford Benefit Management (OBM). OBM will offer comparable dental benefits and include additional products such as Vision, life insurance ($25,000 benefit) and additional discount programs. **Overall annual plan cost will go down from $6,570 to $5,983. Savings of $587. Combined with medical, overall annual increase to Board of $451.**

- Medical and OBM plan summaries will be furnished to all plan members.

<u>Any questions? You can call:</u>

Gente at (866) 693-7254
Horizon BCBS (800) 355-2583
Rocco Siino, Executive Benefits Group (973) 777-5500



Medical Flexible Spending Account

What is a Medical Flexible Spending Account (FSA)?

Medical FSAs are voluntary, employee-owned accounts that use pre-tax dollars to pay for out-of-pocket medical/dental/vision expenses for you and your family members including children up to age 27. The money elected for deposit into an FSA is automatically deducted tax-free from your paycheck in equal installments throughout the year.

A Medical FSA may be a good choice for you if:

- You and/or family members have regular out-of-pocket expenses, such as doctor or prescription drug co-pays, and vision expenses.
- You anticipate major dental work within the next year.

What does it cost to enroll in a Medical FSA?

There is no cost to participate, nor do you have to purchase anything. You also do not have to be covered under your company's medical plan to participate, and your spouse and children are automatically covered. The IRS has historically required that you forfeit any unused money, but you may now carryover up to $500 into the following plan year. It is no longer completely "Use-it-or-lose-it".

After determining the value of your FSA, you cannot change or discontinue that amount unless you experience a "life event," such as marriage, divorce, the birth or adoption of a child, or a change in your spouse's job status.

What are the tax savings?

Your tax savings can be anywhere from 25% - 35%, depending on your tax bracket and residence. For example, if you incur out-of-pocket expenses of $1,000, you will save $250 - $350 – a substantial savings.

IRS Eligible Medical Expenses

The IRS defines eligible health care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. With this in mind, listed below are many of the medical expenses eligible for payment under a Flexible Spending Account that are not covered by your medical or dental insurance. This list is not meant to be all-inclusive.

DENTAL SERVICES

Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extractions
Fillings
Gum Treatment Oral
Surgery
Orthodontia/Braces

INSURANCE RELATED ITEMS

Co-pay and coinsurance amounts
Deductibles
Pre-existing condition expenses (medical)
Private hospital room differential

LAB EXAMS/TESTS

Blood Tests
Cardiographs
Diagnostic
Laboratory fees
Metabolism tests
Spinal fluid tests
Urine/stool analyses
X-rays

MEDICATION

Insulin
Prescribed birth control
Prescribed vitamins
Prescribed drugs

OBSTETRIC SERVICES

Lamaze class
Mid-wife expenses
OB/GYN exams
OB/GYN prepaid maternity fees (reimbursable after date of birth)
Post-natal treatment
Pre-natal treatment

PRACTITIONERS

Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist
Psychologist

OTHER MEDICAL TREATMENTS/ PROCEDURES

Acupuncture
Alcoholism/Substance abuse
Bio-feedback therapy (in medically necessary situations)
Reconstructive surgery (if medically necessary due to a congenital defect or accident)
Drug addiction
Hearing exams
Hospital services
Infertility
In-vitro fertilization
Norplant insertion or removal
Patterning exercises
Physical examination (not employment related)
Physical therapy
Rolfing
Speech therapy
Sterilization
Transplants (including organ donor)
Vaccinations/immunizations
Vasectomy and vasectomy reversal
Weight loss program*
Well baby care

OTHER MEDICAL EQUIPMENT, SUPPLIES AND SERVICES

Abdominal/back supports
Ambulance services
Arches/orthopedic shoes
Bandages
Contraceptives, prescribed
Counseling
Crutches
Guide dog (for visually/hearing impaired person)
Hearing aids & batteries
Hospital bed
Learning Disability (special school/ teacher)
Lead Paint Removal (if not capital expense and incurred for a child poisoned)
Medic alert bracelet or necklace
Oxygen equipment
Prescribed medical and exercise equipment
Prosthesis
Splints/casts
Support hose (if medically necessary)
Syringes
Transportation expenses (essential to medical care)
Tuition fee at special school for disabled child
Weight loss drugs (to treat a specific disease)
Wheelchair
Wigs (hair loss due to disease)

VISION SERVICES

Artificial eyes
Contact lenses
Contact lens solution
Eye examinations
Eyeglasses
Laser eye surgeries
Ophthalmologist
Optometrist
Prescribed sunglasses
Radial keratotomy/LASIK

Ineligible Expenses

The following expenses are ineligible for reimbursement for a Medical FSA under IRS regulations. Expenses to promote general health are not eligible unless prescribed by a physician for a specific medical ailment. This list is not meant to be all-inclusive.

GENERAL

Baby-sitting & child care
Canceled appointment fees
Contact lens insurance
Cosmetic surgery/procedures
Dancing/exercise programs
Diaper service
Discounts/write-offs
Electrolysis
Exercise equipment
Eyeglass insurance
Fitness programs
Hair loss medication
Hair transplant
Health club dues
Illegal operation or treatment
Insurance premium interest charge
Insurance premiums
Marriage counseling
Massage therapy*
Maternity clothes
Nutritional supplements
Personal trainer*
Prescription drug discount program premiums
Rogaine
Student health fee
Swimming lessons
Teeth whitening/bleaching
Vision discount program premiums
Vitamins (for general health)

OVER-THE-COUNTER MEDICATIONS

Over the counter medications are covered with a doctor's prescription.

* Eligible only with a doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension/stress relief does not qualify as an eligible expense.

FSA Worksheet

Your FSA allows you to pay for eligible medical and day care expenses on a pre-tax basis. The money elected for deposit into an FSA is automatically deducted in equal installments from your gross pay before federal, state (except NJ), local and Social Security taxes are withheld. You will have the option to participate in the medical FSA each plan year. This worksheet will help you calculate how much to deposit for your expenses for you and your family members. The IRS requires that you forfeit any unused in excess of $500.

MEDICAL CARE FSA

Medical/Dental/Vision Expenses* **List the amount you spend for:**	**Prior Year Actual Expenses***	**Projected Expenses***
Co-payments\Co-insurance	$	$
Deductibles	$	$
Prescription drug co-pays	$	$
Vision care (eye exams, glasses contact lenses & supplies)	$	$
Well-child care	$	$
Maintenance for chronic medical conditions (e.g. diabetic supplies)	$	$
Dental & orthodontic services	$	$
Other (any approved IRS expense)	$	$
Total	$	$

*Not covered or partially covered under any group insurance plan.

122 Parish Drive-Wayne, NJ 07040 ◆ Toll Free 866-693-7254 ◆ 973-995-1000 ◆ Fax 973-694-4376

SUMMARY OF BENEFITS AND COVERAGE

HRA Plan Year April 1, 2018 thru December 31, 2018

Board of Fire Commissioners District #3
Horizon Plan

To help you with your Horizon deductible expenses a Health Reimbursement Account (HRA) has been established to reimburse expenses up to **$3500** for a single and **$7000** for family coverage.

PCP copay-Employee pays $15/ HRA pays $5; Specialist copay- Employee pays $30 /HRA pays $10. Employee pays the first $1000 deductible single and $2000 for family then HRA plans pays remaining $3500 single and $7000 family.

gente handles the administration of the HRA.

Here's how the HRA works.

- You and the provider will receive an Explanation of Benefits or EOB. The EOB outlines approved charges, the amount you are responsible for, as well as the status of your deductible accumulation.
- Both you and your provider will receive the EOB from the carrier at approximately the same time. You should not pay the provider before you receive the EOB.
- After you receive the EOB you can submit the claim form and EOB to gente for reimbursement of the deductible amount.
- Email claims to claims@gente.solutions or fax to (973)694-2913. You can also submit claims using the mobile app "gente solutions" or uploading your EOB on the website www.gente.solutions/login .
- You will receive a check or direct deposit from gente.
- Pay your provider according to the patient responsibility on the EOB.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan administrator. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.

Any Questions? Call Toll Free (866) 693-7254

ATTACHMENT B

SALARY GUIDE

SALARY GUIDELINES FOR FIREFIGHTER/EMT/FIRE INSPECTOR (FF/EMT/INSP) EFFECTIVE SEPTEMBER 1, 2017

	2017	2018	2019	2020
FF/EMT/INSP 1	$48,000.00	$48,000.00	$48,000.00	$48,000.00
FF/EMT/INSP 2	$53,000.00	$52,000.00	$53,000.00	$54,000.00
FF/EMT/INSP 3	$58,000.00	$56,000.00	$58,000.00	$60,000.00
FF/EMT/INSP 4	$63,000.00	$60,000.00	$63,000.00	$66,000.00
FF/EMT/INSP 5	$68,000.00	$64,000.00	$68,000.00	$72,000.00
FF/EMT/INSP 6	$73,000.00	$68,000.00	$73,000.00	$78,000.00
FF/EMT/INSP 7	$78,000.00	$72,000.00	$78,000.00	$84,000.00
FF/EMT/INSP 8	$83,000.00	$76,000.00	$83,000.00	$90,000.00

SALARY GUIDELINES FOR FIRE LIEUTENANT (LT) EFFECTIVE SEPTEMBER 1, 2017

Promoted Prior to 8/31/17	2017	2018	2019	2020
Current LT	$91,335.00	$93,846.71	$96,427.50	$98,838.18

Promoted On/After 9/1/17	2017	2018	2019	2020
LT 1st Grade	$75,000.00	$81,000.00	$83,835.00	$85,302.11
LT 2nd Grade	$77,312.00	$82,946.00	$89,150.00	$87,614.11
LT 3rd Grade	$79,624.00	$85,258.00	$90,882.00	$89,926.11
LT 4th Grade	$81,936.00	$87,570.00	$93,194.00	$98,838.18

SALARY GUIDELINES FOR FIREFIGHTER/EMT (FF/EMT) EFFECTIVE SEPTEMBER 1, 2017

	2017	2018	2019	2020
FF/EMT 1	$43,000.00	$43,000.00	$43,000.00	$43,000.00

ATTACHMENT C

EXPLANATION OF VISION PLAN BENEFITS

Oxford Benefit Management (OBM) *Benefit Summary for HANOVER TWP FIRE DIST. NO 3*

Effective Date: 04/01/2018
Policy Number: 016499

OBM is a set of pre-packaged specialty products and services, including dental, vision, employee basic life insurance and health discounts.

Dental Insurance Coverage	
Plan Code	P2935
Annual Maximum	$1,500.00 per person per calendar year
Deductible Amount: (In/Out of Network) • Single • Family	 • $50/$50 • $150/$150
Coinsurance: (In/Out of Network) • Preventive/Diagnostic • Minor Restorative • Endodontics / Periodontics / Oral Surgery • Major Care	 • 100%/100% • 80%/80% • 80%/80% • 50%/50%
Waiting Periods for Major Care and Orthodontia	Waiting Period Waived
Vision Insurance Coverage	
Plan Code	ICKQ
In Network Copay amount (Exams/Materials)	$20 / $50
Out of Network coverage allowances	• Exams up to $20 • Lenses up to $40 • Frames up to $25 • Contacts up to $55
Frequency (Exams/Lenses/Frames)	12/12/24 months
Employee Basic Life Insurance Coverage	
Coverage amount	$25,000
Health Discount Program	
Health Discounts	Discounts on health/wellness products and services

Please note, this is a sample summary provided for information purposes only. Coverage is subject to the terms and conditions of the group contract and member Certificate of Coverage.