PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND
PRESCRIPTION DRUG PLAN

2018

INTRODUCTION

The Middlesex County Joint Health Insurance Fund ("Plan Sponsor") established the **Middlesex County Joint Health Insurance Fund Prescription Drug Plan** ("Plan"). The Plan includes prescription drug benefits for eligible employees and retirees of Employer. All references in this document to "Employer" mean the following: (1) the Middlesex County Board of Social Services; (2) the Middlesex County Utilities Authority; or (3) Middlesex County.

This document sets forth the terms of the Plan as of January 1, 2018. Plan Sponsor intends that this document serves as the Plan Document and as the Summary Plan Description, along with the documents supplied by the claim administrators and Employer, for the prescription drug benefits under the Plan.

The prescription drug benefits under the Plan are provided on a self-funded basis. This means that these benefits will be paid by Plan Sponsor from its general assets, rather than through an insurance company. Plan Sponsor has selected a claim administrator for the self-funded prescription drug benefits under the Plan. The claim administrator is not an insurer of the Plan, and any and all references in the documents to the claim administrator should be interpreted accordingly. The "OTHER BASIC INFORMATION ABOUT THE PLAN" section identifies the claim administrator for the prescription drug benefits under the Plan.

The existence of the Plan does not grant employees any legal right to continue employment with Employer or affect the right of Employer to discharge employees. Questions about the Plan/Summary Plan Description should be directed to Plan Sponsor.

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

Dated: December 31, 2017

David Hissey
Signature

David Hissey
Printed Name and Title

Fund Administrator

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PRESCRIPTION DRUG PLAN

The Plan includes only prescription drug benefits. Other benefits (e.g., medical, dental, and vision) may be available under a separate plan, and are set forth in a different document maintained by the plan administrator.

ELIGIBILITY AND PARTICIPATION

The following individuals are eligible to receive prescription drug benefits under the Plan:

Middlesex County Board of Social Services

Eligible employees of and retirees from the Middlesex County Board of Social Services ("Board of Social Services") are eligible to participate in the Plan.

The eligibility and participation rules for employees and retirees are set forth in documents (e.g., an employment policy or collective bargaining agreement) maintained by the Board of Social Services. For purposes of determining eligible employees and retirees and their participation dates, those documents are incorporated into the Plan by reference.

Middlesex County

The following retirees from Middlesex County (the "County") are eligible to participate in the Plan:

- Employees who retire from the County before January 1, 2019, except for the following:
  - Employees who retire as Direct Billed Retirees.
  - Employees who retire due to a disability.
- Employees who retire from the County before January 1, 2021 with 25 or more years of creditable service in the state of New Jersey's administered pension plan as of December 31, 2011 as Premium Free Retirees.

The eligibility rules for retirees are set forth in documents (e.g., an employment policy or collective bargaining agreement) maintained by the Count. For purposes of determining eligible retirees, those documents are incorporated into the Plan by reference.

Additionally, qualified beneficiaries who elected continuation coverage under COBRA before January 1, 2018 are eligible for continuation coverage as required by COBRA (see the section entitled "CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA" for more information).

Middlesex County Utilities Authority

The following retirees from Middlesex County Utilities Authority ("Utilities Authority") are eligible to participate in the Plan:

- Employees who retire from the Utilities Authority before January 1, 2019, except for the following:
  - Employees who retire as Direct Billed Retirees.
  - Employees who retire due to a disability.
- Employees who retire from the Utilities Authority before January 1, 2021 with 25 or more years of creditable service in the state of New Jersey's administered pension plan as of December 31, 2011 as Premium Free Retirees.

The eligibility rules for retirees are set forth in documents (e.g., an employment policy or collective bargaining agreement) maintained by the Utilities Authority. For purposes of determining eligible retirees, those documents are incorporated into the Plan by reference.

Additionally, qualified beneficiaries who elected continuation coverage under COBRA before January 1, 2018 are eligible for continuation coverage as required by COBRA (see the section entitled "CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA" for more information).

For more information about Employer's eligibility and participation rules, which are incorporated into the Plan by reference, contact your specific Employer (or former Employer).

DEPENDENT ELIGIBILITY AND PARTICIPATION

This section sets forth the eligibility and participation rules for a participant's spouse and dependent children for the self-funded prescription drug benefits under the Plan.

Spouse

A participant's spouse is eligible to participate in the Plan.

"Spouse" means a person who is legally married to an employee. Plan administrator may require documentation proving the existence of a legal marriage.

Note: Surviving spouses of participants who are Premium Free Retirees and who die on or after January 1, 2018 are considered to be Direct Bill Retirees and are eligible for the same prescription drug benefit as the deceased participant at the time of the participant's death.

Dependent Children

An eligible dependent child includes the following:

- The employee's natural child, legally adopted child, or child placed with the employee for adoption.
- The employee's step child.
- The employee's foster child.
- A child for whom the employee is required to provide medical care under a qualified medical child support order ("QMCSO"). (See the QMCSO subsection under the "Special Rules Regarding the Health Benefits" section for information about the required coverage for children covered by a QMCSO.)

An eligible child may participate in the Plan until the end of the calendar year during which the child turns age 26. However, if a child becomes totally disabled before age 26, benefits may continue beyond the limiting age provided the child is unmarried and is incapable of financial self-support. Proof of disability may be periodically required by the plan administrator.

Note: Dependents of participants who are Premium Free Retirees and who die on or after January 1, 2018 are considered to be Direct Bill Retirees and are eligible for the same prescription drug benefit as the deceased participant at the time of the participant's death.

INITIAL ENROLLMENT RULES

When employees and retirees initially become eligible to participate in the Plan, they may elect to participate in the prescription drug benefits provided under the Plan by applying for coverage and agreeing to pay any required premium contributions. Employees and retirees are permitted to elect to participate in the Plan, regardless of whether the employee or retiree elects to participate in a plan providing medical benefits that is sponsored by Plan Sponsor.

ANNUAL AND SPECIAL ENROLLMENT PERIODS

Annual Enrollment

Before the beginning of each plan year, Plan Sponsor will notify employees and retirees of the dates for the open enrollment period. During the open enrollment period, employees and retirees will have the opportunity to make benefit election changes. Benefit elections will remain in effect until the end of the plan year unless the employee requests an election change due to a change in status or other qualifying event (see the summary plan description for Employer's Section 125 plan for details), or the employee or retiree has a special enrollment rights circumstance as explained below. (**Note**: The rules under Section 125 of the Internal Revenue Code generally don't apply to retirees because retirees do not pay their potion of the cost of coverage under the Plan on a pre-tax basis. As a result, retirees may generally drop coverage under the Plan at any time during the year. Retirees

may not, however, enroll in coverage under the Plan at any time during the year, absent a special enrollment right.)

Special Enrollment

If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee or retiree, and/or a dependent may have special enrollment rights to participate in prescription drug benefits under the Plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. But a loss of other coverage for this purpose does not include a termination for:
  - Nonpayment of required contributions.
  - Filing of a fraudulent application or claim.
  - Voluntary termination of the other coverage.
- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer may contribute to the cost of the Plan. In addition, employees and retirees may be required to contribute to the cost of the Plan, as periodically determined by Employer. Employer will notify employees and retirees of any required contribution.

The Plan is funded on a self-funded basis. Plan Sponsor will pay these benefits from its general assets. The Plan Sponsor may also purchase insurance to protect the Plan Sponsor from large individual and aggregate losses.

If Employer maintains a Section 125 plan, any required participant contributions (if applicable) may be paid on a pre-tax basis by employees (but generally not retirees) under Employer's Section 125 plan.

SCHEDULE OF BENEFITS

Copayments

The copayment applied to each covered prescription drug is shown in the schedule below. The copayment is not a covered expense under the Plan.

If a prescription drug is purchased from a non-participating pharmacy, or a participating pharmacy without your ID card, you must submit your claim to the claim administrator for reimbursement.

ACCOUNT AND COPAY STRUCTURE FOR MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND					
Umbrella Group # MCJHIF1		Retail = Card and Direct - In- and Out-o-Network for up to 34 DS or 100 units (whichever is greater)		Mail (up to 90 DS)	
Group #	Benefit Group Name	Retail Generic	Retail Brand	Mail Generic	Mail Brand
MCJHIFCOCO003	Admin. Cob 03	$5	$10	$5	$10
MCJHIFCOCO035	Admin. Cob 35	$5	$10	$5	$10
MCJHIFCOU65DB03	Admin. Pre-65 Direct Bill 03	$0	$3	$0	$3
MCJHIFCOO65DB03	Admin. Post-65 Direct Bill 03	$0	$3	$0	$3
MCJHIFCOU65PF03	Admin. Pre-65 Prem Free 03	$0	$3	$0	$3
Group #	Benefit Group Name	Retail Generic	Retail Brand	Mail Generic	Mail Brand
MCJHIFCOO65PF03	Admin. Post-65 Prem Free 03	$0	$3	$0	$3
MCJHIFSSACTU	Soc Svcs Act Union	$5	$10	$5	$10
MCJHIFSSACTNU	Soc Svcs Non-Union	$5	$10	$5	$10
MCJHIFSSCOBU	Soc Svcs Cob Union	$5	$10	$5	$10
MCJHIFSSACTNU	Soc Svcs Cob Non-Union	$5	$10	$5	$10
MCJHIFSSU65DB03	Soc Svcs Pre-65 Direct Bill 03	$0	$3	$0	$3
MCJHIFSSU65PF03	Soc Svcs Pre-65 Prem Free 03	$0	$3	$0	$3
MCJHIFSSO65DB03	Soc Svcs Post-65 Direct Bill 03	$0	$3	$0	$3
MCJHIFSSO65PF03	Soc Svcs Post-65 Prem Free 03	$0	$3	$0	$3
MCJHIFUTCOB	Util Cobra	$5	$10	$10	$20
MCJHIFUTU65DB	Util Pre-65 Direct Bill	$5	$10	$10	$20

MCJHIFUTU65PF	Util Pre-65 Prem Free	$5	$10	$10	$20
MCJHIFUTO65DB	Util Post-65 Direct Bill	$5	$10	$10	$20
MCJHIFUT065PF	Util Post-65 Prem Free	$5	$10	$10	$20
Employees who retire from the County or the Utilities Authority in 2019 or 2020 with 25 or more years of creditable service in the state of New Jersey's administered pension plan as of December 31, 2011 as Premium Free Retirees		$5	$10	$5	$10
Preventive Medications are medications prescribed to prevent the occurrence of a disease or condition for individuals with risk factors, or to prevent the recurrence of a disease or condition for individuals who have received, and do not include drugs used to treat an existing illness, injury or condition. Preventive medications may include those used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency. For additional information on Preventive Medications, please contact the claims administrator. **The copayment for preventive medications is $0.**					

Types of Prescriptions

Here is an explanation of the types of prescriptions that are available under the Plan:

- **Generic:** The chemical equivalent of its brand-name counterpart. The cost of a brand-name drug includes research, patent, and advertising expenses. When the patent expires, other manufacturers are able to duplicate the drug at a fraction of the cost. As a consumer, when you buy a generic drug, you are buying the same formula as the brand-name drug without helping to pay for the overhead. The U.S. Food and Drug Administration ("FDA") must certify that a generic drug meets the same safety, strength, and effectiveness standards as the original brand-name drug.

- **Brand-Name Formulary:** A brand-name drug that is on a preferred list (i.e., formulary). Formulary drugs are FDA-approved and selected based on effectiveness and safety records. Typically, the claim administrator is able to negotiate a lower cost with the manufacturer for formulary drugs. That discount is passed on to you in the form of a lower copayment. To view the current list of formulary prescription drugs, you may log onto the claim administrator's website (https://www.caremark.com/wps/portal). You should confirm that your prescribed drug is contained on the current formulary. If not, you should talk to your doctor about possible alternatives. The formulary is changed periodically, so you should also review the formulary periodically.

- **Brand-Name Non-Formulary:** A brand-name drug that does not have a generic equivalent or is not on the current formulary, or a brand-name drug that you choose, even though a generic equivalent or formulary equivalent is available.

Types of Pharmacies

Here is an explanation of the types of pharmacies at which you may have prescriptions filled:

- **In-Network Retail Pharmacy:** A CVS pharmacy or another licensed pharmacy in the retail network. A list of the participating in-network pharmacies is available on the claim administrator's website, which can be accessed here: www.caremark.com/wps/portal.

- **Out-of-Network Retail Pharmacy:** A licensed retail pharmacy that is not in the retail network. If you fill a prescription at an out-of-network pharmacy, you may be required to pay for your prescription and submit a claim for reimbursement to the claim administrator.

- **Mail Order Pharmacy:** A licensed pharmacy operated by the claim administrator where prescriptions are filled and delivered to you by mail.

Covered Prescription Drugs

Prescription drugs that are covered by the Plan include medications, products, and devices that have been approved by the FDA and can only be dispensed with a prescription from a licensed provider (i.e., legend drugs). Covered prescription drugs may also include over-the-counter ("OTC") items that can be purchased from a pharmacy (and, in some cases, without a prescription). Unless otherwise excluded (see the subsection entitled "Excluded Prescription Drugs" below) include the following:

- Federal legend drugs
- State restricted drugs
- Insulin
- OTC and legend needles and syringes
- Insulin pumps and accessories
- Injectable contraceptives
- Emergency contraceptives
- Plan B, through age 16
- Fertility agents
- Accutane, through age 25
- Legend anti-obesity preparations
- Depo-provera/Depo-SubQProvera
- Pre-packaged oral contraceptives
- Nutritional therapy for specific medical conditions (OTC and legend)
- Relenza/Tamiflu
- Inhaler assisting devices (OTC and legend)
- Progesterone in oil
- Antihemophila agents
- Systemed self-injectable drugs
- Diabetic supplies, insulin needles, syringes (OTC and legend)

- Androgenic agents
- Specialty pharmacy drugs
- Botox/Myobloc/Dysport/Xeomin
- Preventive medications (e.g., aspirin, folic acid, iron), subject to age limitations
- Smoking deterrents, age 18 and over
- Pediatric fluoride vitamin drops
- Drugs to treat impotency (except Yohimbine), for males age 18 and over

If you have questions about whether a prescription drug is covered under the Plan, you should contact the claims administrator.

Excluded Prescription Drugs

The following are not covered under the Plan:

- Costs for any prescription drugs that are not medically necessary, or that are above reasonable and customary charges
- Charges incurred by an individual before becoming a participant in the Plan
- Costs for the following:
    - Non-federal legend drugs
    - Compound medications
    - Federal non-legend drugs
    - Investigational drugs
    - Homeopathic drugs
    - Contraceptive devices or implantable contraceptives (these items are covered under the plan providing medical benefits)
    - Injectable medications, unless specifically covered (see the subsection entitled "Covered Prescription Drugs" above)
    - Synagis
    - Ostomy supplies
    - Oral hyperglycemias
    - Nutritional supplements and combination nutritional products
    - Biologicals, immunization agents, vaccines, allergy sera, blood or blood plasma products
    - Drugs that are labeled "Caution-limited by Federal law to investigational use," or experimental drugs
    - Medications for which the cost is recoverable under any workers' compensation or occupational disease law, state or governmental agency, or medication furnished by any other drug or medical services for which you are not charged
    - Any prescription that is refilled more than the number of refills specified in the prescription, or any refill dispensed more than one year after the date of the prescription
    - Charges for the administration or injection of any drug

Preauthorization

For your health and safety (and the health and safety of your covered spouse and dependents), your prescription drug benefits under the Plan includes utilization review of prescription drug usage. The claim administrator will evaluate and certify your need for certain drugs, medicines, and supplies, and may periodically make formal assessments of the medical necessity, effectiveness, and appropriateness of prescription drug usage, and treatment plans on a prospective, concurrent, and retroactive basis.

Certain drugs may require preauthorization by the claim administrator before it is covered under the Plan. The Plan reserves the right to limit benefits under the Plan to prevent over-utilization of drugs or medicines. If patterns of over-utilization or misuse of drugs or medicines is detected, the claim administrator will notify your doctor and pharmacy. Your doctor may request that the claim administrator review a decision denying preauthorization at any time. The following medications require preauthorization:

- Androgens and anabolic steroids
- Cosmetics (Botox/Myobloc/Dysport/Xeomin)
- Growth hormones
- Multiple Sclerosis therapy (e.g, Specialty PTPA)

Submitting a Claim

In-Network/Mail Order

You do not need to file a claim for reimbursement when you use an in-network retail pharmacy or the mail order program to fill a prescription. Except for your copayment, which is required at the time you purchase your prescription, these expenses are paid directly by the Plan.

Out-of-Network

If you use an out-of-network retail pharmacy to fill a prescription, you must pay for the prescription. You may then submit a claim form to the claim administrator to be reimbursed for amount of your payment (less the required copayment). When you submit the claim form to the claim administrator, you may be required to include receipts or other information from the pharmacy that filled the prescription, and a written statement that the expense has not been reimbursed and will not be reimbursed under any other health insurance policy or benefit plan. To submit a claim for reimbursement, you should contact the claim administrator.

TERMINATION OF COVERAGE

To remain eligible for benefits under the Plan, the employee or retiree must continue to be an eligible employee or retiree according to the eligibility rules maintained by Employer (those rules are incorporated into the Plan by reference). However, prescription drug benefits under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and

Medical Leave Act of 1993 ("FMLA"). (See the "Family and Medical Leave Act" subsection.) The employee must pay the same premium amount for the prescription drug benefits during the leave as actively-working employees.

Further, if an employee is laid off or goes on a non-FMLA Employer-approved leave of absence, prescription drug benefits under the Plan may be able to be continued, depending on the eligibility rules maintained by Employer (those eligibility rules are incorporated into the Plan by reference). If prescription drug benefits may be continued in these situations, the employee must pay the same premium amount for the prescription drug benefits during the layoff or leave of absence as actively-working employees.

Prescription drug benefits under the Plan will terminate on:

- The date an individual ceases to be eligible for benefits in accordance with the Employer's eligibility rules, which are incorporated into the Plan by reference.
- The first day any required participant contributions are not timely paid.
- The effective date of the individual's voluntary withdrawal from the Plan due to a change in status or during an open enrollment period.
- The date the Plan is discontinued as a whole.
- The date on which the participant's coverage is terminated for cause by the plan administrator. (Termination for cause means the participant is found to have misrepresented information in the application for participation or on a claim for benefits.)

In certain circumstances after coverage ends as described above, the employee or retiree, and/or his or her eligible dependents may be eligible for COBRA continuation coverage, as explained in the following sections.

CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA

The federal law known as COBRA allows eligible individuals to temporarily extend prescription drug coverage under the Plan in certain circumstances where coverage would otherwise end. The federal law known as USERRA gives employees who cease to be eligible for prescription drug coverage due to service in the U.S. military additional rights regarding continuation of prescription drug coverage. This section provides information regarding extensions of coverage under these laws.

COBRA Continuation Coverage

COBRA continuation coverage allows the employee or retiree, and/or his or her dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end.

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The employee or retiree, and his or her spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator.

Eligibility

The employee or retiree, and/or his or her dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee or retiree during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours[1] or termination of employment[2]	Employee and Dependents	18
Employee's/Retiree's death	Dependents	36
Employee's/Retiree's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's/Retiree's divorce/ legal separation[3]	Dependents	36
Commencement of Bankruptcy proceeding under Title 11 of the United States Code with respect to Employer	Retiree and Dependents	For a qualified beneficiary who is the retiree - until the qualified beneficiary's death. For qualified beneficiaries who are the spouse, surviving spouse, or dependent children of the retiree upon the occurrence of the qualifying event - the earlier of the date of the qualified beneficiary's death or 36 months after the retiree's death.

Extension of Continuation Coverage

If the employee and/or his or her dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or his or her dependents in the three circumstances described below ("extension events").

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[1] A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

[2] Continuation coverage is not available if employment is terminated for gross misconduct.

[3] Elimination of the employee's or retiree's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

Employee's Entitlement to Medicare

If the employee becomes entitled to Medicare benefits during the initial 18-month period, his or her dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before his or her termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that the employee or one of his or her dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide the employee or retiree, and his or her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted based on the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event

occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided based on the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, the employee or retiree, and/or his or her dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee or retiree, and/or his or her dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The employee or retiree, one of the employee's or retiree's dependents, or an individual acting on behalf of the employee or retiree, and/or the employee's or retiree's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided based on the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit

or is not provided based on the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The notice form may be obtained by contacting the plan administrator at the address or telephone number listed at the end of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee, or retiree.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the relevant court documents establishing the legal separation.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may

be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the prescription drug coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the prescription drug coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. However, coverage is initially available only if the

qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications may apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

Other Coverage Options

There may be other coverage options for you and your family. Now that key parts of Health Care Reform have taken effect, you have the opportunity to buy coverage through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and his or her dependents keep the plan administrator informed of any changes in address. They should also keep a copy, for their records, of any notices they send to the plan administrator.

Continuation of Health Coverage Upon Military Leave

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and his or her eligible dependents will be offered the opportunity to continue health coverage based on the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). (Retirees are not eligible for USERRA continuation coverage.) The employee and his or her dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to his or her military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

An employee may elect to continue health coverage under the Plan for himself or herself and his or her eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or
- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If an employee gives Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee's notice as an election to continue health coverage during his or her military service unless the employee specifically informs Employer, in writing, that he or she wants to cancel health coverage during his or her military leave. The employee will have to pay the required premiums for his or her health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during his or her military service.

If an employee gives Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of his or her right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for himself or herself and his or her eligible dependents. Unlike COBRA, the employee's

dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of his or her family, the employee must elect it for himself or herself and all eligible dependents who are covered under the Plan when the employee's military service begins.

If an employee chooses USERRA continuation coverage, he or she must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and his or her eligible dependents.

A special rule applies if the employee does not give Employer advance notice of his or her military service. In that case, the employee and his or her eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of his or her eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of his or her military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);
- The employee affirmatively elects to reinstate the coverage; and
- The employee pays all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31st day of his or her military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment.

However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll himself or herself and his or her eligible dependents in health coverage immediately upon returning to active employment, even if the employee and his or her eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods.

SPECIAL RULES REGARDING THE PRESCRIPTION DRUG BENEFITS

There are several special rules which apply to the health benefits under the Plan. This section summarizes those special rules.

Qualified Medical Child Support Orders ("QMCSO")

Despite any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a QMCSO. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

Health Care Reform

The prescription drug benefits under the Plan have been amended and will continue to be amended to comply with the insurance market reforms of the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act ("HCERA"). Collectively, the PPACA and the HCERA are known as Health Care Reform. The required changes included the following:

- Dependent children must be eligible to participate in the prescription drug benefits under the Plan until at least the child's 26th birthday. However, prescription drug benefits under the Plan have been extended until the end of the calendar year in which the child turns age 26.

- Lifetime limits on the dollar value of essential health benefits under the Plan no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan.

- Annual limits on the dollar value of essential health benefits under the Plan no longer apply.

- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice is required before coverage may be retroactively terminated due to fraud or material misrepresentation.

- Pre-existing condition limitations or exclusions no longer apply.

- The Plan is not a grandfathered plan under Health Care Reform. Accordingly, the following additional insurance market reforms under Health Care Reform apply:

    - The Plan must provide certain preventive care items and services without required participant cost-sharing.

    - The Plan must provide certain patient protections such as:

        - Where a participant is required to have a primary care physician (PCP), the participant may designate any participating PCP, including a pediatrician, as the PCP.

        - The Plan may not require preauthorization or referral when a participant seeks coverage for obstetric or gynecological care from a participating OB-GYN.

        - The Plan may not require preauthorization for emergency services.

        - The Plan may not impose a copayment amount or coinsurance rate for emergency services in an out-of-network emergency department of a hospital that exceeds the requirements for in-network emergency services.

        - Maximum out-of-pocket limits are restricted.

        - Certain routine patient costs associated with clinical trials are covered.

    - Participants must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo a new external review procedure.

For more information concerning Health Care Reform or any of these required changes, please contact the plan administrator.

Health Insurance Portability and Accountability Act

Under the Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, certain privacy and security rules apply to the Plan. Specifically, group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements. (See the "HIPAA PRIVACY AND SECURITY RULES" section for further details.)

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if an employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

CLAIM AND APPEAL PROCEDURES

The claims procedures for the self-funded prescription drug benefits are as follows:

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or

the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date

it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided based on the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health claim by submitting a written application to the Plan within 180 days following receipt of the denial of the claim. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination.

In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit. The claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. The Plan will not base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be one or two levels of appeal for pre-service health claims. In either case, the appeal process must be completed within 30 days and notification must be provided to the claimant.

Post-Service Health Claims

There will be one or two levels of appeal for post-service health claims. In either case, the appeal process must be completed within 60 days and notification must be provided to the claimant.

External Review

The claimant may submit a request for an external review with respect to a denied claim. The external review procedure must comply with the requirements of Health Care Reform. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

- The claimant had coverage under the Plan at the time the service or supply was provided;
- Whether the claimant has exhausted the Plan's internal appeal process unless not required to do so as described above; and
- Whether the claimant has provided all information and forms necessary to process the external review.

Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan will assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan will take action against bias and to ensure independence. Contracts will be in place with at least three IROs. External reviews will be rotated among the IROs. In addition, an IRO will not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO will make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.

- Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

- Upon any receipt of any information submitted by the claimant, the IRO must, within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

- The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim "de novo" (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review including the claimant's medical records, the attending health care professional's recommendation, reports from appropriate health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider, the terms of the Plan, appropriate practice guidelines (including applicable evidence-based standards), any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law, and the opinion of the IROs clinical reviewer(s).

- The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The

IRO must deliver the notice of its final external review decision to the claimant and the Plan.

- The IRO's decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

- After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility.

- Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meet the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.

- Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

- The IRO will provide notice of its decision in the same manner as a standard external review and will do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-funded benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim. If the Plan fails to strictly adhere to the internal claim and appeal procedures described above, the claimant will be deemed to have exhausted the internal claim and appeal procedures and as a result, may initiate an external review and/or file a legal proceeding. However, this rule will not apply to minor, de minimis violations.

COORDINATION OF BENEFITS

If you are covered by another group health plan or policy, whether insured or self-insured, that covers prescription drugs, the following rules determine which plan (this Plan or the other plan) is primary, and which plan is secondary:

- If the other plan does not contain a coordination of benefits provision or states that it is the primary plan, the other plan is the primary plan and this Plan is the secondary plan.

- If the other plan contains a coordination of benefits provision, benefits will be paid as follows:

- The plan that covers the claimant as an active member (such as an employee) is the primary plan, and the plan that covers the claimant as an inactive member (such as a retiree) is the secondary plan.

- The plan that covers the claimant as an employee or retiree is the primary plan, and the plan that covers the claimant as a dependent is the secondary plan.

- If the claimant is a dependent child, the plan of the non-dependent (employee/retiree or spouse) with the birthday that occurs earliest in the calendar year is the primary plan.

  If the non-dependents have the same birthday, the plan that covered the claimant for the longest period of time is the primary plan and the plan the covered the claimant for the shortest period of time is the secondary plan. To determine the length of time that the claimant has been covered under a plan, two or more plans maintained by the same Employer is treated as one plan.

- For the children of divorced or separated spouses, benefits are determined in the following order unless a court order assigns financial responsibility to one parent.

  - The plan of the custodial parent.
  - The plan of the custodial parent's new spouse (if remarried).
  - The plan of the non-custodial parent.
  - The plan of the non-custodial parent's new spouse (if remarried).

RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT

Plan's Right to Reimbursement

If the Plan pays benefits to you or on your behalf, and another party (other than you or the Plan) is (or may be) liable for the expenses for which benefits were paid, the Plan has a right of reimbursement that entitles the Plan to recover from you or the other party 100% of the benefits paid by the Plan to you or on your behalf.

The Plan's right to reimbursement applies:

- Not only to any recovery that you receive or you are entitled to receive from the other party, but also to any recovery that you receive or you are entitled to receive from the other party's insurer or a plan under which the other party has coverage.

- To any recovery from your own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy.

- Even if the other party is not found to be legally at fault for causing you to incur the expenses paid by the Plan.

- To any recovery, even if the damages are recovered or are recoverable from the other party, its insurer or plan, or your policy are not for the same charges or types of losses or damages as those for which benefits were paid by the Plan.

- To any recovery, regardless of whether the recovery fully compensates you for your injuries, and regardless of whether you are made whole by the recovery.

- To the entire amount of the recovery, but only to the extent of the amount of benefits paid by the Plan. The Plan's right to reimbursement from the recovery is the first in priority, and is not offset or reduced in any way by your attorney's fees or costs incurred in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of your attorney's fees or costs in obtaining the recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

Plan's Subrogation Right to Initiate Legal Action

If you do not bring an legal action against the other party who caused the need for benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan has the right to bring an action against the other party to enforce and protect its right to reimbursement as described in this section. In this circumstance, the Plan is responsible for its own attorney's fees.

Your Cooperation

You must cooperate fully and do whatever is necessary to secure the rights of the Plan described in this section. This includes assigning to the Plan your rights against any other party, and signing any legal documents that may be required by the Plan.

Plan's Right to Withhold Payment

The Plan may withhold payment of benefits when it appears that a party other you (or the Plan) may be liable for expenses for which benefits are claimed until such liability is legally determined. Further, as a pre-condition to paying benefits when it appears that the need for the benefits paid by the Plan was caused by another party, the Plan may withhold the payment of benefits until you sign an agreement furnished by the plan administrator setting forth the Plan's right to reimbursement and subrogation right.

Preconditions to Participation and the Receipt of Benefits

All of the following rules are preconditions to your participation in the Plan and your receipt of benefits from the Plan:

- You agree not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and you acknowledge that the Plan expressly disavows such claims or defenses.

- You agree not to raise any jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

- You acknowledge that if you obtain or become entitled to obtain a recovery from another party who is or may be liable for expenses for which the Plan paid benefits, that the Plan has an equitable lien over that recovery. The equitable lien applies over any recovery to the extent of the amount of benefits paid by the Plan.

- You acknowledge that the Plan has the right to intervene in any third-party action to enforce the Plan's reimbursement rights and you consent to such intervention.

- You agree that the Plan has the right to obtain injunctive relief prohibiting you from accepting or receiving any settlement or other recovery related to the expenses for which the Plan paid benefits until the Plan's right to reimbursement is fully satisfied, and you consent to such injunctive relief.

Notice and Settlement of Claim

You must give the plan administrator written notice of any claim against another party as soon as you become aware that you may be entitled to recover damages from another party. You are deemed to be aware that you may be entitled to recover damages from another party upon the earliest of the following events:

- The date that you retain an attorney in connection with the claims; or

- The date that you, or your insurer or attorney present a written notice of the claim to the other party, or the other party's insurer or attorney.

You must not compromise or settle any claim against another party without the prior written consent of the plan administrator. If you fail to provide the plan administrator with written notice of a claim as required in this section, or if you compromise or settle a claim without the prior written consent as required in this section, the plan administrator will deem you to have committed fraud or misrepresentation in a claim for benefits, and your participation in the Plan will be terminated.

ADMINISTRATION

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

Plan Sponsor, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-funded benefits to a third party administrator. Such a third party administrator may be a named fiduciary for benefit appeals pursuant to the applicable benefits.

AMENDMENT OR TERMINATION

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

HIPAA PRIVACY AND SECURITY RULES

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification (see below), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Despite the provisions of the Plan to the contrary, Plan Sponsor will not be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.

- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.

- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.

- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan

Sponsor will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan will disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or
- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Plan Sponsor

- The employees, or classes of employees, listed in Plan Sponsor's HIPAA privacy policies and procedures will be given access to PHI.
- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.
- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.
- To comply with the HIPAA security rules, Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

Definitions

For purposes of this section, the following terms have the following meanings:

- **"Business Associate"** means a person or entity who:
  - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or
  - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- **"Plan Administrative Functions"** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.
- **"Protected Health Information"** or **"PHI"** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition

of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant's information are considered to enable identification:

- Names;
- Street address, city, county, precinct, zip code;
- Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;
- Telephone numbers, fax numbers and electronic mail addresses;
- Social Security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic or code.

- **"Summary Health Information"** means information that may be individually identifiable health information:
  - That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and

- From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

GOVERNING LAW

The Plan is subject to various federal laws, including, but not limited to the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, HIPAA, FMLA, COBRA, USERRA and Health Care Reform, and may be subject to certain state laws. To the extent federal law does not apply, the Plan will be interpreted under the laws of the state of New Jersey.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Middlesex County Joint Health Insurance Fund Prescription Drug Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Plan Sponsor:	Middlesex County Joint Health Insurance Fund c/o The County John F. Kennedy Square, 3rd Floor P.O. Box 871 New Brunswick, NJ 08903 22-3382140
Website	www.mcjhif.com
Type of Plan:	Group Health Plan providing prescription drug benefits.
Type of Administration:	The Plan is administered by plan administrator. The plan administrator may retain the services of a claim administrator to provide administrative services.
Plan Administrator:	Plan Sponsor
Agent for Service of Legal Process:	Fund Attorney c/o The County John F. Kennedy Square, 3rd Floor P.O. Box 871 New Brunswick, NJ 08903 Service of legal process may also be made on the plan administrator.
COBRA Administrator:	Wage Works 4609 Regent Boulevard Irving, Texas Phone: (888) 678-4861 Fax: (877) 864-9552
Claim Administrators:	**Prescription Drug Benefits:** CVS/Caremark

Plan Year for Fiscal Record Purposes: January 1 through December 30