PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND HEALTH PLAN

2021

INTRODUCTION

The Middlesex County Joint Health Insurance Fund ("Plan Sponsor") established the **Middlesex County Joint Health Insurance Fund Health Plan** ("Plan"). The Plan includes medical 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; (3) Middlesex County; (4) Middlesex County Improvement Authority; (5) Roosevelt Care Center; (6) Middlesex County College; or (7) Middlesex County Mosquito Commission.

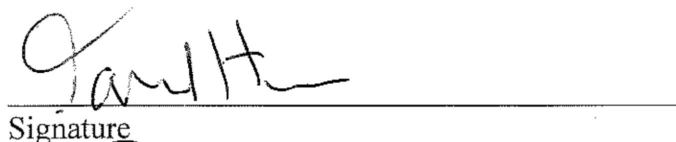
This document sets forth the terms of the Plan as of January 1, 2021. Plan Sponsor intends that this document serves as the Plan Document and as the Summary Plan Description, along with the documents supplied by the claim administrators and Employer, for the medical benefits under the Plan. **The Plan is not subject to the federal Employee Retirement Income Security Act of 1976 ("ERISA") despite any provision or statement in the documents supplied by the claim administrators to the contrary.**

The medical 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 various claim administrators for the self-funded medical benefits under the Plan. A claim administrator is not an insurer of the Plan, and any and all references in the documents to a claim administrator should be interpreted accordingly. The "**Error! Reference source not found.**" section identifies the claim administrators for the medical 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 should be directed to Plan Sponsor.

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

Dated: May 19, 2021



Signature

David Hissa

Printed Name and Title

Fund Administrator

TABLE OF CONTENTS

Page

HEALTH PLAN 1

ELIGIBILITY AND PARTICIPATION 2

- Middlesex County Board of Social Services 2
- Middlesex County 2
- Middlesex County Utilities Authority 2
- Middlesex County Improvement Authority 3
- Roosevelt Care Center 3
- Middlesex County College 3
- Middlesex County Mosquito Commission 3

DEPENDENT ELIGIBILITY AND PARTICIPATION 4

- Spouse 4
- Dependent Children 4

INITIAL ENROLLMENT RULES 5

ANNUAL AND SPECIAL ENROLLMENT PERIODS 5

- Annual Enrollment 5
- Special Enrollment 5

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE 6

TERMINATION OF COVERAGE 7

CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA 7

- COBRA Continuation Coverage 8
- Continuation of Health Coverage Upon Military Leave 17

SPECIAL RULES REGARDING THE MEDICAL BENEFITS 20

- Qualified Medical Child Support Orders (“QMCSO”) 20
- Health Care Reform 20
- Newborns’ and Mothers’ Health Protection Act 21
- Women’s Health and Cancer Rights Act 21
- Health Insurance Portability and Accountability Act 22
- Family and Medical Leave Act 22

CLAIM AND APPEAL PROCEDURES 22

ADMINISTRATION 23

AMENDMENT OR TERMINATION 23

Page

HIPAA PRIVACY AND SECURITY RULES 23

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI") .. 23
Conditions of Disclosure 23
Certification of Plan Sponsor 25
Permitted Uses and Disclosures of Summary Health Information 25
Adequate Separation Between Plan and Plan Sponsor 25
Disclosure of Certain Enrollment Information to Plan Sponsor 26
Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage 26
Other Disclosures and Uses of PHI 26
Definitions 26

GOVERNING LAW 28

OTHER BASIC INFORMATION ABOUT THE PLAN 29

HEALTH PLAN

The Plan includes the following medical benefit options:

- Aetna Health Maintenance Organization ("HMO") Plan (Opt Out)
- Aetna Health Maintenance Organization ("HMO") Plan (Opt In)
- Cigna Network Medical Benefits Plan (Opt In)
- Cigna Network Medical Benefits Plan (Opt Out)
- Horizon Blue Cross Blue Shield of New Jersey – BlueCard Preferred Provider Organization ("PPO") (PPO Opt Out and PPO Opt In)
- Horizon Blue Cross Blue Shield of New Jersey – Choice Point-of-Service ("POS") (Choice Opt Out and Choice Opt In)
- Horizon Blue Cross Blue Shield of New Jersey – OMNIA
- Horizon Blue Cross Blue Shield of New Jersey – Traditional
- Horizon Garden State Plan (only available to employees of the Middlesex County College as of January 1, 2022)
- Horizon Educators Plan (only available to employees of the Middlesex County College as of July 1, 2021)

Eligible employees and retirees have received or will receive documentation prepared by the claim administrators that describes the medical benefit for which they are enrolled. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the documentation prepared by the claim administrators, unless otherwise noted in this Summary Plan Description.

The other documentation for the medical benefits will contain the following information:

- A summary of the medical benefits.
- A description of any applicable deductibles, coinsurance, or copayment amounts.
- A description of any limits on the medical benefits.
- Whether and under what circumstances preventive services are covered.
- Provisions governing the use of network providers (if any). If there is a network, the documentation will contain a general description of the provider network. Participants are entitled to obtain an up-to-date list of providers in the network, which is frequently available on the claim administrator's website.

- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.
- A description of the circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

ELIGIBILITY AND PARTICIPATION

The following individuals are eligible to receive medical 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

Eligible employees of and retirees from Middlesex County (the "County") 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 County. For purposes of determining eligible employees and retirees and their participation dates, those documents are incorporated into the Plan by reference.

Middlesex County Utilities Authority

Eligible employees of and retirees from Middlesex County Utilities Authority ("Utilities Authority") 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 Utilities

Authority. For purposes of determining eligible employees and retirees and their participation dates, those documents are incorporated into the Plan by reference.

Middlesex County Improvement Authority

Eligible employees of and retirees from the Middlesex County Improvement Authority ("MCIA") 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 MCIA. For purposes of determining eligible employees and retirees and their participation dates, those documents are incorporated into the Plan by reference.

Roosevelt Care Center

Eligible employees of and retirees from the Roosevelt Care Center ("RCC") 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 RCC. For purposes of determining eligible employees and retirees and their participation dates, those documents are incorporated into the Plan by reference.

Middlesex County College

Eligible employees of the Middlesex County College ("MCC") are eligible to participate in the Plan.

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

Middlesex County Mosquito Commission

Eligible employees of and retirees from the Middlesex County Mosquito Commission ("MCMC") 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 MCMC. For purposes of determining eligible employees and retirees and their participation, those documents are incorporated into the Plan by reference.

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

Note to Medicare eligible retirees: For eligible retirees who are also eligible for Medicare based on age (65 years of age) or disability (determined to be disabled by the Social Security

Administration), the retiree must enroll in both Medicare Parts A and B. Medicare Parts A and B pay benefits on a primary basis to this Plan. This Plan pays benefits on a secondary basis to Medicare Parts A and B.

It is the retiree's responsibility to enroll in Medicare Parts A and B. If the retiree fails to enroll in Medicare Parts A and B, the Plan will still pay benefits on a secondary basis as if the retiree was enrolled in Medicare Parts A and B. This may result in the retiree being billed for expenses that would have been paid by Medicare Parts A or B if the retiree had been properly enrolled.

DEPENDENT ELIGIBILITY AND PARTICIPATION

This section generally sets forth the eligibility and participation rules for a participant's spouse and dependent children for the self-funded medical benefits under the Plan. **However, in the event of any conflicts between the eligibility and participation rules for a participant's spouse and dependent children below, and the eligibility and participation rules for a participant's spouse and dependent children in other documents maintained by the Employer (e.g., an employment policy or collective bargaining agreement), the eligibility and participation rules for a participant's spouse and dependent children in the other documents maintained by the Employer (e.g., an employment policy or collective bargaining agreement) will control.**

Spouse

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

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

Note to Medicare eligible spouses: For eligible spouses who are also eligible for Medicare based on age (65 years of age) or disability (determined to be disabled by the Social Security Administration), the spouse must enroll in both Medicare Parts A and B. Medicare Parts A and B pay benefits on a primary basis to this Plan. This Plan pays benefits on a secondary basis to Medicare Parts A and B.

It is the spouse's responsibility to enroll in Medicare Parts A and B. If the spouse fails to enroll in Medicare Parts A and B, the Plan will still pay benefits on a secondary basis as if the spouse was enrolled in Medicare Parts A and B. This may result in the spouse being billed for expenses that would have been paid by Medicare Parts A or B if the spouse had been properly enrolled.

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 more 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.

INITIAL ENROLLMENT RULES

When employees and retirees initially become eligible to participate in the Plan, they may elect to participate in the medical benefits provided under the Plan by applying for coverage and agreeing to pay any required premium contributions.

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. The Middlesex County College offers an open enrollment period as of every January 1 and July 1.

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 portion 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 individual 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 medical 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 medical benefits from its general assets or assets that are maintained in a trust fund. 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.

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, medical benefits under the Plan can be continued if an 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 medical 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, medical 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 medical benefits may be continued in these situations, the employee must pay the same premium amount for the medical benefits during the layoff or leave of absence as actively-working employees.

Otherwise the medical benefits under the Plan will terminate on the earliest of the following:

- 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 medical benefits 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 medical benefits due to service in the U.S. military additional rights regarding continuation of medical benefits. 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 medical benefits 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").

---

[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 medical benefits 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 medical benefits 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). For more information on the interaction between COBRA and Medicare, see the "COBRA Continuation Coverage and Medicare" subsection below.

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.

COBRA Continuation Coverage and Medicare

In general, if an employee does not enroll in Medicare Part A or B when first eligible because he/she is still employed, after the Medicare initial enrollment period, the employee has an eight month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after his/her employment ends; or
- The month after group health plan coverage based on current employment ends.

If the employee does not enroll in Medicare and elects COBRA continuation coverage instead, the employee may have to pay a Part B late enrollment penalty and have a gap in coverage if the employee wants Part B later. If the employee elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the employee enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If the employee is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation

coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the employee is not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Other Coverage Options

There may be other coverage options for you and your family. 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 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 MEDICAL BENEFITS

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

Qualified Medical Child Support Orders ("QMCSO")

Despite any contrary provision 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 medical 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 medical benefits under the Plan until at least the child's 26th birthday. However, medical 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 were 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 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.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including

lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

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 appeal procedures are set forth in the Middlesex County Joint Health Insurance Fund Risk Management Plan (the "Risk Management Plan") maintained by the Plan Sponsor. You may request a copy of the Risk Management Plan by contacting the Plan Administrator.

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 the claim and appeal procedures.

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 Health Plan
Name, Address, and Taxpayer Identification Number of Plan Sponsor:	Middlesex County Joint Health Insurance Fund 75 Bayard Street New Brunswick, NJ 08903 22-3382140
Type of Plan:	Group Health Plan providing medical 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 Middlesex County Joint Health Insurance Fund 75 Bayard Street 3rd Floor New Brunswick, NJ 08903 Service of legal process may also be made on the plan administrator.
COBRA Administrator:	24 Hour Flex PO Box 3789 Littleton, CO 80161 Phone: (303) 481-1574

Claim Administrators:	**Aetna HMO Plan (Opt Out)** is administered by Aetna Life Insurance Company **Aetna HMO Plan (Opt In)** is administered by Aetna Life Insurance Company **Cigna Network Medical Benefits Plan (Opt In)** is administered by Cigna Health and Life insurance Company **Cigna Network Medical Benefits Plan (Opt Out)** is administered by Cigna Health and Life insurance Company **PPO Opt Out and PPO Opt In** is administered by Horizon Blue Cross Blue Shield of New Jersey **Choice Opt Out and Choice Opt In** is administered by Horizon Blue Cross Blue Shield of New Jersey **OMNIA** is administered by Horizon Blue Cross Blue Shield of New Jersey **Traditional** is administered by Horizon Blue Cross Blue Shield of New Jersey **Horizon Garden State Plan** is administered by Horizon Blue Cross Blue Shield of New Jersey **Horizon Educators Plan** is administered by Horizon Blue Cross Blue Shield of New Jersey
Plan Year for Fiscal Record Purposes:	January 1 through December 31