SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

SUPPLEMENTAL SUMMARY PLAN DESCRIPTION

FOR:

TOWNSHIP OF DELRAN

HEALTH BENEFIT PLANS

2023

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Introduction

This is the Supplemental Summary Plan Description for the health benefit plans (medical and prescription drug) provided by the TOWNSHIP OF DELRAN (the "Employer") through the Southern New Jersey Regional Employee Benefits Fund (the "Fund").

The Fund is a joint self-insurance fund established pursuant to New Jersey statutes (N.J.S.A. 40A:10-36 et. seq.) consisting of certain municipalities and other Local Units eligible to participate in a joint insurance fund who have elected to participate in the Fund, referred to as the Fund, (each a "Member" or collectively "Members") to provide for contributory or non-contributory group health insurance to employees, and their dependents, of the Members through self-insurance, the purchase of commercial insurance or reinsurance, or any combination thereof.

The Fund contracts with various third-party providers in order to make available to its Members a comprehensive program of health care which provides health care services and benefits to the eligible employees, and their dependents, of Fund Members. The Fund has contracted with AETNA LIFE INSURANCE COMPANY (hereinafter "Aetna") and EXPRESS SCRIPTS, INC. ("ESI") (Aetna and ESI are sometimes hereinafter referred to individually or collectively as "Administrator") to provide certain administrative services to the Fund and to process the payment of claims for the services and supplies provided to Participants (as hereinafter defined) pursuant to the terms of the contracts between the Administrator and the Fund and the terms of this Agreement.

The purpose of this SSPD is to provide you with information about your Health Benefit Plan (hereinafter sometimes referred to as the "Plan"). In the event that you have questions after reading this SSPD and the attached Aetna Medical Plan Description or Prescription Drug Plan Summary Plan Description, please contact your Employer's personnel/human resources department or use the contact information in this SSPD or on your health insurance identification (ID) card to contact the appropriate representative.

The goal of your Employer and this Health Benefit Plan is providing for your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating pharmacies, physicians and hospitals is available to provide you with easy access to health care providers and services 24 hours a day, 7 days a week. We believe that through the appropriate use of health care resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Benefit Plan is self-funded by your Employer through the Fund and is administered by Aetna or ESI dependent upon the benefit involved. The Fund and your Employer reserve the right to amend or terminate this Health Benefit Plan, in whole or in part, at any time, subject to applicable law. In the event that your Employer has implemented a Section 125 Plan as provided under the Internal Revenue Code of 1986, as amended, (the "Code") your participation in this Health Benefit Plan may require that you agree to reduce your compensation or to forego all or part of an increase, if applicable, in your compensation and to have such amounts contributed by your Employer on your behalf to the payment of the cost of your coverage under the Health Benefit Plan.

ARTICLE ONE

Definitions and Interpretation

Section 1.1 Definitions. Where the following words and phrases appear in this SSPD, they shall have the respective meanings set forth below, unless their context clearly indicates otherwise. Capitalized terms not defined in this SSPD will have the meaning given to them in the applicable documents attached to or incorporated in this SSPD.

Dependent means a Spouse of an Employee or any individual who is a child of an Employee (including a biological or adopted child, foster child, step child, and any other child for whom the Employee has legal guardianship), who is eligible to participate in the Plan pursuant to the terms of one or more Health Benefit Plans, and who is a "dependent" as defined in the applicable eligibility criteria established by the Employer. "Foster Child" means an unmarried child under the limiting age for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction. A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Effective Date of this SSPD is January 1, 2023. The effective date of the Health Benefit Plan is set forth in Schedule A.

Employee is any person who, as of the first day of employment with the Employer, is a common-law employee of the Employer, except leased employees (as defined in Section 414(n) of the Code.

Employer is the Township of Delran.

Health Benefit Plan means the specific health or medical benefit arrangement or prescription drug plan identified in Schedule A under which the Employer

provides health and medical or prescription drug benefits. A Plan may be amended from time to time by the Employer.

Participant or Plan Participant is any individual who has properly enrolled in, and who participates in a Health Benefit Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate further in that benefit plan. Participation requirements are described in the individual Health Benefit Plan.

Plan shall mean, both individually and collectively as appropriate in the context, the Aetna Choice POS II and HMO Medical Plans and/or ESI Prescription Drug Plan, described in Schedule A and attached as part of Exhibit I, offered by the Employer to its Employees as the same may be amended from time to time.

Plan Administrator is Aetna in the case of the medical benefits plan and ESI in the case of the prescription benefits plan; each of whom will perform their respective duties and responsibilities as detailed in this document or the documents of their respective Plan.

Plan Year is the 12-month period beginning on January 1 and ending in December 31. The Plan Year for each Health Benefit Plan is set forth in Schedule A.

Special Programs are described in the Aetna Plan Description attached as part of Exhibit I and are health and wellness programs offered by Aetna which are ancillary programs and informational resources made available to you but are not part of the core benefits under the medical plan provided by your Employer. These Special Programs may be added or removed from the Plan at any time, with or without notice.

Spouse is the wife or husband of an Employee, as determined under New Jersey law, who continues to be legally married to an Employee and is not divorced, divorced from bed and board, legally separated or had an annulment of the marriage to the Employee.

All other defined terms in the SSPD shall have the meanings specified in the various Articles of the SSPD in which they appear.

Section 1.2 Interpretation. Whenever a noun or pronoun is used in this SSPD in plural form and there is only one person within the scope of the word so used, or in singular form and there be more than one person within the scope of the word so used, such word or pronoun shall have a plural or singular meaning as the case may be. Likewise, pronouns of one gender shall include the other gender. The words "herein," "hereof," and "hereunder" shall refer to this SSPD. Headings are given to the Articles and Sections of the SSPD only for the purpose of convenience and to make the document easier to read. Headings, numbering, and paragraphing shall not in any case be deemed material or relevant to the interpretation of the SSPD or its contents.

Section 1.3 Purpose. The purpose of this Supplemental Summary Plan Description is to supplement and amend the Aetna Plan Description and Prescription Drug Plan Summary Plan Description attached hereto as part of Exhibit I (the "SPD") in order to explain how the Employer provides health benefits to its Employees through the Fund. Benefits are provided pursuant to the Plan(s) described in the SPD. Every effort has been made to ensure the accuracy of this Supplemental Summary Program Description and the SPD; however, State law and the New Jersey Administrative Code govern the Fund. If you believe that there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, then the law, regulations, and contracts will govern

ARTICLE TWO

Eligibility and Participation

Section 2.1 Eligibility. The eligibility requirements for benefits under the Plan are set forth in each Health Benefit Plan and are summarized in Schedule A-1.

Section 2.2 Participation. Any Employee who is eligible to participate in the Plan and who is properly enrolled in the Plan shall be a Participant in the Plan.

Section 2.3 Termination of Participation. Participation will terminate on the date an Employee is no longer eligible to participate in a Health Benefit Plan. An Employee may become ineligible for any benefit under the Plan if such Employee fails to pay the applicable contributions or meet other requirements of a particular Health Benefit Plan.

Section 2.4 Participant's Rights. The Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this SSPD or the Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect such discharge shall have upon him or her as a Participant of the Plan. Further, neither the establishment of the Plan or any amendment thereof nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Fund, the Employer or the Administrator, except as provided therein.

Section 2.5 Medicare Coverage Required. A Participant and/or eligible spouse, or child who is eligible for Medicare coverage by reason of ESRD (defined below) or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or retain coverage under the Plan and active employees who are eligible for Medicare based upon age should consider enrolling in Medicare Parts A and B. A Participant will be required to submit documentation of enrollment in Medicare Parts A and B when he/she becomes eligible for that coverage. Acceptable documentation includes a photocopy of a Medicare card showing both Part A and B enrollment or a letter from Medicare indicating the effective dates of both Parts A and B coverage. Send your evidence of enrollment to your Employer or to the

Administrator at the address set forth in the Plan. If a Participant does not submit evidence of Medicare coverage under both Parts A and B, the Participant and/or his/her dependents will be terminated from the Plan in the event such coverage is required. Upon submission of proof of full Medicare coverage, the Participant's coverage will be reinstated on a prospective basis.

a. If a provider does not participate with Medicare, no benefits are payable under the Plan for the provider's services.

b. A Participant may be eligible for Medicare for the following reasons: (i) Age: This applies to a Participant who is the retiree or eligible spouse and is at least 65 years of age. A Participant is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday. In this event the Plan shall be the secondary plan if your employer is a large group health plan. (ii) Disability: This applies to a Participant who is under age 65. A Participant is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months. In this event this Agreement shall be the secondary plan. (iii) End Stage Renal Disease: This applies to a Participant who is being treated for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when: (i) the individual has group health coverage of their own or through a family member (including a spouse); (ii) the group health coverage is from either a current employer or a former employer. If a Participant is Medicare eligible solely due to ESRD, and has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the Plan will be primary. Following that there is a thirty (30) month Coordination of Benefits ("COB") period with Medicare secondary to coverage provided under the Plan. At the expiration of the COB period, Medicare is the primary payer and the coverage under the Plan is secondary. In the event the Participant was not actively employed becomes eligible for Medicare and then becomes ESRD eligible, the Plan will be the secondary payor and there is no thirty (30) month COB period.

c. Participants who reside outside the United States must maintain their Medicare coverage (Parts A and B) in order to be covered under the Plans.

ARTICLE THREE

Incorporation by Reference

Section 3.1 Incorporated Documents. This SSPD incorporates the documents, including any administrative service agreements or other contracts, containing the substantive provisions governing the Plan. The documents describing the Plan are provided to employees as a companion to this document. If the Plan documents are amended or superseded, the amended or successor documents will automatically become incorporated documents. If there is no provision in an incorporated document corresponding to a provision of this SSPD, to the extent applicable, the SSPD provisions will apply to the incorporated document.

Section 3.2 Benefits Available. The benefits available shall consist of the benefits available under the Plan, including all limitations and exclusions with respect to each Health Benefit Plan's benefits. The benefits available under each Health Benefit Plan are set forth in the Health Benefit Plan documents which are attached as part of Exhibit I. The availability of benefits is subject to payment by the Employer and the Participant, if applicable, of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Health Benefit Plan. A Summary of Benefits is attached as Exhibit "II".

ARTICLE FOUR

Administration of the Plan

Section 4.1 Section 4.1 Plan Administrator. With respect to the determination of the amount of, and entitlement to, benefits under the Plan, Aetna is the Plan Administrator with respect to the medical benefits plan and ESI is the Plan Administrator with respect to the Prescription Benefits Plan, each with the full power to interpret and apply the terms of their respective Plan as they relate to the benefits provided under the applicable Health Benefits Plan.

Section 4.2 Delegation. The Plan Administrator may delegate to any committee, person, or employee, officer or agent of Plan Administrator, the Fund or the Employer any one or more of its powers, functions, duties or responsibilities with respect to the Plan. Any such delegation of responsibilities may be amended from time to time in writing by the Plan Administrator and may be revoked in whole or in part at any time by written notice from one party to the other.

Section 4.3 General. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. A named fiduciary may designate persons other than the named fiduciaries to carry out its fiduciary responsibilities under the Plan.

Section 4.4 Interpretation and Findings of Fact. The Fund and the applicable Plan Administrator for the particular Plan (to the extent necessary to pay or adjudicate claims with respect to any Health Benefit Plan for which it provides benefits) shall have sole and absolute discretion to interpret the provisions of the Plan. This includes, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan, determining the rights and status under the Plan of Participants and other persons, to decide disputes arising under the Plan, to make factual determinations, and to make any determinations and findings with respect to the benefits payable and the persons entitled to benefits as may be required for the purposes of the Plan.

Section 4.5 Assistance. The Plan Administrator may employ such clerical, legal, actuarial, accounting, or other assistance or services that it believes are necessary or advisable in connection with the performance of its duties.

Section 4.6 Insuring and Funding Benefits. Funding for the Plan shall consist of the sum of all collected assessments paid by the Employer (and Participants, if applicable) for the purpose of

funding all of the Health Benefit Plans offered by the Fund to the Employer. The Fund shall have the right to pay benefits from its general assets, insure any benefits under the Health Benefit Plans, and establish any fund or trust for the holding of contributions or payment of benefits under the Health Benefit Plans, either as mandated by law or as the Fund deems advisable. In addition, the Fund shall have the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Health Benefit Plans, including, but not limited to, any trust or insurance policy. If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier. To the extent funds are transferred to or accumulated in a trust to provide any benefit, that benefit will be payable from the assets of such trust.

Section 4.7 Right to Receive and Release Information. For the purpose of determining the applicability of and implementing the terms of the provisions of the Plan, the Administrator and/or the Fund may release to, or obtain from, any other plan or policy administrator, insurance company, or other organization or individual any information, concerning any individual, which the Administrator and/or Fund considers to be necessary for those purposes. Any individual claiming benefits under the Plan will furnish the information that may be necessary to implement the provisions of the Plan.

Section 4.8 Other Plans The Administrator shall not be required to determine the existence of any health benefit or insurance plan or the amount payable under any such health benefit or insurance plan except those under the Plan, and the payment of benefits under this Health Benefit Plan shall be affected by the benefits payable under any and all other health benefit or insurance plans only to the extent that the Administrator is furnished with information relative to such other plans by the Employer or the Participant or any other insurance company or organization or person.

Section 4.9 PIP Coverage This Plan will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) under your automobile insurance policy unless you have elected to have this Plan as the primary coverage by or for the employee covered under this Plan. This election is made by the named insured under the PIP program and affects the employee's family members who are not themselves the named insured under another automobile insurance policy. This Plan may be primary for one family member but not for another if the individuals have separate automobile insurance policies and have made different elections regarding which health insurance coverage is primary.

If this Plan is primary to PIP coverage, or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions and limits set forth in the health plan document issued by the Administrator and only for those services normally covered under this Plan. If you have elected to have this Plan primary to PIP, prior notification to the Administrator is not required. However, upon receipt of an auto-related claim, the Administrator will request that you provide written documentation, such as a copy of your automobile insurance policy declaration page, to verify the election and that this Plan is to be primary to PIP.

If this Plan is secondary to your PIP coverage, the benefits payable will be the lesser of: (i) the remaining uncovered allowable expenses after PIP has provided coverage, subject to medical need at the appropriate level of care and other applicable provisions of this Plan, after deduction of deductibles and coinsurance; or (ii) the actual benefits that would have been payable had this Plan been primary.

Section 4.10 Workers' Compensation. . We do not cover services and supplies which are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt, may exclude themselves or are not required by law to be covered under any Workers' Compensation Act or similar law

ARTICLE FIVE

Amendments, Terminations and Mergers

Section 5.1 Right to Amend. The Fund and your Employer reserve the right to amend this SSPD and any Health Benefit Plan from time to time, including amendments that are retroactive in effect to the extent permitted by law.

Section 5.2 Plan Merger. The Fund and your Employer reserve the right to merge the Plan (or any part thereof) and any other Health Benefit Plan at any time.

Section 5.3 Right to Terminate. The Fund and your Employer may terminate the Plan (or any part thereof) and any other Health Benefit Plan in whole or in part at any time, in accordance with applicable law.

Section 5.4 Payment of Claims Upon Termination. Upon termination of the Plan (or any part thereof), the Plan shall continue until all pending claims for benefits outstanding as of the date of termination have been paid.

ARTICLE SIX

Guarantees and Liabilities

Section 6.1 No Guarantee of Employment. Nothing contained in this SSPD shall be construed as a contract of employment between the Employer and an Employee or Participant, or as a right of any Employee or Participant to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee or Participant, with or without cause.

Section 6.2 No Guarantee of Non-Taxability. Neither the Fund nor the Employer makes a representation or guarantee that any amounts deposited or credited on behalf of or reimbursed to an Employee or Participant under the Plan will be excluded from the Employee's or Participant's gross income for Federal, state or local income tax purposes.

Section 6.3 Withholding Taxes. To the extent an Employer is required to withhold Federal, state, local or foreign taxes in connection with any payment made to an Employee or Participant

under a Health Benefit Plan, the Employer shall withhold the amount so determined from the payment.

Section 6.4 Incapacity to Receive Payment. If the Plan Administrator finds that any Participant entitled to receive benefits under the Plan is, at the time such benefits are payable, unable to care for his affairs because of a physical, mental, or legal incompetence, the Plan Administrator may, in its sole discretion, pay the benefits to which the Participant was entitled to one or more persons chosen by the Plan Administrator from among the following: the institution maintaining or responsible for the maintenance of such Participant, his/her Spouse, his/her children, or other relative by blood or marriage. Any payment made under these circumstances shall be a complete discharge of all liability under the Plan with respect of such payment.

Section 6.5 Severability Provision. If any provision of this SSPD or the application of a provision of a Health Benefit Plan to any circumstance or person is invalid, the remainder of this SSPD and the Health Benefit Plan and their application to other circumstances or persons shall not be affected thereby.

Section 6.6 Right of Recovery. The Fund and the Plan Administrator shall have the right to recover any payment either of them made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment. Whenever payments have been made by the Plan Administrator for Covered Medical Services (or, if applicable, for prescription drugs) in excess of the maximum amount of payment necessary at that time to satisfy the provisions of the Health Benefit Plan, inclusive of the Coordination of Benefits terms, irrespective of to whom paid, the Plan Administrator shall have the right to recover the excess from among the following, as the Plan Administrator shall determine: any person to or for whom such payments were made, any insurance company, or any other organization. The Participant, personally and on behalf of his or her Covered Dependents shall, upon request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the Plan Administrator's rights to recover the excess payments.

ARTICLE SEVEN

Claims Procedures

Section 7.1 Benefit Claims. Claims for benefits must be filed in accordance with the specific procedures contained in the Plan. Most of the Health Benefit Plans offered to the Employer by the Fund do not require benefit claims to be filed when routine services are provided. The address of the party responsible for the review of claims made under the Plan is set forth in summaries attached as Exhibit I. All other general claims or requests should be directed to the Administrator.

Section 7.2 General Claims Procedure. In the event a claim for benefits is required, written proof of the claim must be furnished to the Administrator within 90 days after the date when the services were provided. Failure to furnish the notice of claim within the time required will not invalidate nor reduce any benefit if it is not reasonably possible to give the notice of claim within

90 days, provided the notice of claim is furnished as soon as reasonably possible. A notice of claim form may be obtained from the Administrator. If the Participant does not receive such form before the expiration of 15 days after the Administrator receives the request, the Participant shall be deemed to have complied with the requirements of the Plan upon submitting within the time fixed in the Plan written notice describing the date of service, service provider name and address, a description of service(s) and/or supplies provided and, if known, the charges. However, in case of a claim for which the Plan provides any periodic payment contingent upon continued provision of Covered Medical Services, this notice may be furnished within 90 days after termination of each period for which the Plan is responsible for payment.

Section 7.3 Disputed Claims or Denial of Claims. The following procedures will be followed if a claim under the Plan is denied, in whole or in part.

a. The Administrator will make a decision on your claim. In the event the Administrator makes an Adverse Benefit Determination, you will be advised in writing of the reason(s) for the determination in accordance with the following chart unless otherwise provided in the applicable SPD attached as part of Exhibit I. The Plan is not governed by ERISA so the claim and appeal procedure set forth in the SPD and this SSPD establishes the applicable procedure for review and appeal of claim decisions.

b. A Participant may appeal an Adverse Benefit Determination to the Administrator within thirty (30) days of the date of the Adverse Benefit Determination by sending a letter stating why the Participant believes the Adverse Benefit Determination should not have been made, including a copy of the Adverse Benefit Determination and any additional information that the Participant wants considered. Information identifying the Participant, the provider's name and address, the claim number, if any, and the date of service for which benefits were denied must be included with the letter. If a Participant does not submit an appeal within the 30-day period, the Adverse Benefit Determination will become final and incontestable.

c. If a Participant is dissatisfied with the determination of the Administrator, the Participant may appeal in writing the Adverse Benefit Determination, as set forth above.

The Administrator will provide you with written notice of an Adverse Benefit Determination within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from the Administrator will provide important information that will assist you in making an appeal of the Adverse Benefit Determination, if you wish to do so.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: Seriously jeopardize your life or health, or your ability to regain maximum function; or Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As promptly as possible but no more than 72 hours.
Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim, dependent upon the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days.

d. The time periods described in the chart may be extended. In the case of Urgent Care Claims, if the Administrator does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after the Administrator receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided. For non-urgent pre-service and post-service claims**,** the time frames may be extended for up to 15 additional days for reasons beyond the Administrator's control. In this case, the Administrator will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied. If an extension is necessary because the Administrator needs more information to process your post service claim, the Administrator will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. The Administrator will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after the Administrator receives the information, if earlier). If you fail to provide the information, your claim will be denied.

e. You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent, designating your authorized representative, to the Administrator. In case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal. Depending on the type of appeal, you and/or an authorized representative may attend the appeal hearing and question the representative of the Administrator and any other witnesses and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Administrator also has the right to present witnesses. If the Administrator's appeals process upholds the original Adverse Benefit Determination, you may have the right to pursue an external review of your claim. See “External Review” for more information.

Section 7.4 External Review If a Participant is dissatisfied with the determination of the Administrator, the Participant may appeal in writing the Administrator's determination to the Fund in accordance with the "Adverse Benefit Determination" appeal process adopted by the Fund in accordance with applicable law and as set forth in the Fund's Risk Management Plan. The "Adverse Benefit Determination" appeal process shall provide, when required, for review by an Independent Review Organization ("IRO") and the participant shall be notified, in writing, of their appeal rights to the IRO and how to file an appeal of an "Adverse Benefit Determination" with the IRO. The Participant's identity shall be revealed only upon the written request of the Participant. A copy of the Participant's appeal and written request with the Participant's name shall be sent to the Fund's Program Manager.

a. An appeal of an Adverse Benefit Determination ("ABD") must be filed by the participant/claimant within 180 days from the date of receipt of the notice of the ABD. The written request for an appeal shall be submitted to the Program Manager who will conduct a preliminary review and advise the claimant if (i) the request is not eligible for external review; (ii) that additional information is needed to make the request complete and what is needed to complete the request; or (iii) the request is complete and is being forwarded to the IRO. There is no right to an external review by the IRO if (1) the claimant is or was not eligible for coverage at the time in question or (2) the ABD or final internal ABD is based upon the failure of the claimant or covered person to meet requirements for eligibility under the Plan or (3) the claimant is not eligible due to the benefit/coverage being an excluded benefit or not included as a covered benefit.

b. The Program Manager shall forward an eligible, complete request for external review to the IRO designated by the Fund who shall be required to conduct its review in and impartial, independent and unbiased manner and in accordance with applicable law.

c. The IRO shall complete the external review in a timely manner, as required by applicable law, and shall deliver written notice of its final external review decision to both the claimant and the Program Manager for all external reviews conducted. The decision of the IRO is binding on the claimant and the Fund, subject to the claimant's right to seek judicial review of the same.

d. A Participant may contact the New Jersey Health Insurance Consumer Assistance Office at NJ Department of Banking and Insurance, 20 West State Street, PO Box 329, Trenton, NJ 08625; phone (800) 446-7467 or (888) 393-1062 (appeals); website: http://www.state.nj.us.dobi/division_insurance/managedcare/umappeals.htm; e-mail: ihcap.dobi.nj.gov.

Section 7.5 Claim Fiduciary. The Fund, through its Executive Committee, has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, the Fund has discretionary authority to: (i) determine whether, and to what extent, you and your covered dependents are entitled to benefits; and (ii) construe any disputed or doubtful terms of the Plan. The Fund has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The Fund may not abuse its discretionary authority by acting arbitrarily and capriciously.

Section 7.6 Legal Action. No action at law or in equity may be brought to recover under the Health Benefit Plan until the expiration of sixty (60) days after a notice of claim has been furnished to the Administrator in accordance with the requirements of the Health Benefit Plan. No such action may be brought after the expiration of three (3) years after the time the notice of claim is required to be furnished under the Health Benefit Plan.

Section 7.7 Assignment Not Permitted. Coverage and your rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding. The benefits contained in this Plan and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person, Provider, Hospital or other entity. The right of a Participant to receive benefit payments under this Plan is personal to the Participant and is not assignable, in whole or in part to any person, Provider, Hospital or other entity. Any assignment not in accordance with Plan terms is void and of no effect and an assignee shall acquire no rights.

ARTICLE EIGHT

Subrogation and Right of Recovery

Section 8.1. Definitions. As used throughout this provision, the term "Responsible Party" means any party, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage. For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Section 8.2 Subrogation. Immediately upon paying or providing any benefit under the Plan, the Plan and the Fund shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

a. If a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

b. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan and to the Fund.

c. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

d. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan and/or the Fund may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile. The Covered Person shall do nothing after a loss to prejudice this right of recovery. The Covered Person must cooperate with the Plan and/or any representatives of the Fund in completing such forms and in giving such information surrounding any accident as the Plan and/or Fund or their representatives deem necessary to fully investigate the incident.

e. The Plan and the Fund are also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment or otherwise. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted above, but only to the extent of the benefits provided under the Plan.

ARTICLE NINE

Continuation of Coverage

Section 9.1 Medical Leave of Absence. A dependent child who would otherwise be eligible for coverage as a full-time student but is on a medically necessary leave of absence from a post-secondary educational institution may receive up to one year of continued coverage subject to the terms and conditions otherwise applicable to COBRA continuation coverage as set forth in the Plan attached hereto.

Section 9.2 COBRA Coverage The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see “Duration of Coverage” on page 16), and the member must pay the full cost of the coverage plus an administrative fee. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

a. Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

b. Under COBRA you may elect to enroll in any or all of the coverages that you had as an active employee or dependent (health and prescription drug), and may change your health or prescription plan when enrolling in COBRA. You may also elect to cover the same dependents that were covered while an active employee, or delete dependents from coverage however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, civil union, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

c. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

d. Effective for plan years beginning on and after January 1, 2014, a dependent child who would otherwise be eligible for coverage as a full-time student but is on a medically necessary leave of absence from a post-secondary educational institution may receive up to one year of continued coverage subject to the terms and conditions otherwise applicable to COBRA continuation coverage as set forth below.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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. Also, other health insurance coverage options may be available to you through the Health Insurance Marketplace described on page 18. For more information about the Marketplace visit www.Healthcare.gov.

Section 9.3. Availability of Continuation Coverage. Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce (from the bonds of matrimony or from bed and board, or annulment), legal separation, dissolution of a civil union or same-sex domestic partnership (makes spouse or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.

- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Section 9.4 Cost of COBRA Coverage. If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Section 9.5 Duration of COBRA Coverage. COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because **of termination of employment, a reduction in hours, or a leave of absence**. Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first. If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

a. COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or same-sex domestic partnership,** or he or she becomes ineligible for continued group coverage because of **marriage, civil union, domestic partnership, attaining age 26**, or because you **elected Medicare as your primary coverage.**

Section 9.6 Employer Responsibilities Under COBRA. The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse/partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;

- Notify the Fund and ESI within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Section 9.7 Employee Responsibilities Under COBRA. The law requires that the employee and/or your dependents:

- Notify your employer (even if you are retired) that a divorce, legal separation, dissolution of a civil union or same-sex domestic partnership, or your death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Section 9.8 Failure to Elect COBRA Coverage In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause. Beginning in 2014 plans will not be able to have pre-existing condition exclusions.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you. As of January 2014, individual policies may not impose pre-existing condition exclusions.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you. In addition, starting in

October 2013, you will be able to buy coverage through the Health Insurance Marketplace, also known as the Health Insurance Exchange (the "Marketplace"). In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments) right away and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). 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 does not accept late enrollees, if you request enrollment within 30 days (a "special enrollment period"). Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Section 9.9 Termination of COBRA Coverage Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the Fund; or
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

Section 9.10 Insurance Exchange Option. There may be other coverage options for you and your family. As of October 1, 2013, health insurance exchanges were established under the terms of the Affordable Care Act, and you will be able to buy coverage through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your out-of-pocket costs for deductibles, coinsurance and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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 For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

ARTICLE TEN
Health Insurance Portability and Accountability Act (HIPAA)

Section 10.1 Effective Date. This Article 10 sets forth certain disclosures and requirements contained in HIPAA which apply to the Plan, your Employer, the Fund and the Administrator. This notice is effective as of January 1, 2023 and additional information about HIPAA can be found at www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html or contact your employer's privacy official listed on Schedule A-1.

Section 10.2 Definitions. For purposes of this Article 10, the following capitalized terms shall have the following meanings:

a. "Authorization" means an authorization by an individual that permits the Plan to use or disclose Protected Health Information that complies with the requirements of Federal medical privacy regulations.

b. "HIPAA" means the federal law identified as the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder, which requires certain non-federal governmental group health plans to implement certain provisions contained in HIPAA or notify its Participants of filings made by the group health plan to exempt itself from certain of the provisions of HIPAA as well as implement certain provisions to prevent the disclosure of Protected Health Information.

c. "Plan Administration Functions" means administration functions performed by the Administrator and/or the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any of its other benefits or benefit plans.

d. "Protected Health Information" means individually identifiable health information of the Plan that is (i) transmitted by electronic media, (ii) maintained in any medium described as electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" does not include individually identifiable health information in education records covered by the Family Educational Right and Privacy Act.

e. "Summary Health Information" means information, that may be individually identifiable health information, and:

(i) that summarizes the claims history, claims expense, or type of claims experienced by individuals for whom the Employer has provided health benefits under a Group Health Plan; and

(ii) which contains no information which could be used to individually identify the person to whom the health information pertains inclusive of any unique identifying number, characteristic, or code except a code or other means of de-identifying and re-identifying information permitted under HIPAA.

Section 10.3 Use and Disclosure of Protected Health Information.

a. Except as specifically provided under this Section 10.3 or as otherwise authorized under a valid Authorization, the Plan, in order to disclose Protected Health Information to the Employer or to provide for or permit the disclosure of Protected Health Information by a health insurance carrier, shall restrict uses and disclosures of such information by the Plan or the Administrator consistent with the requirements set forth in this Article 10.

b. The Plan or the Administrator may disclose Summary Health Information to the Fund or the Employer, if the Fund or the Employer requests the Summary Health Information for the purpose of:

(i) obtaining premium bids for providing health insurance coverage under the Plan; or

(ii) modifying, amending, or terminating the Plan.

c. The Plan or the Administrator may disclose to the Fund or the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

d. The Administrator may use or share your health information as follows:

(i) **Manage Treatment.** We can use and disclose Protected Health Information and share it with professionals who are treating you.;

(ii) **Genetic Information.** We are not allowed to use genetic information when deciding to provide coverage or the price of that coverage to you; and

(iii) **Plan Administration.** We can use and disclose Protected Health Information to the Fund or the Employer to carry out Plan Administration Functions to the extent consistent with the provisions of this Article 10. We may disclose your health information to your health plan sponsor for plan administration e.g. provide certain statistics to explain the cost of coverage and reconcile billings and process claims and for fraud and abuse detection.

(iv) **Permitted Uses and Disclosure.** We may, as an example and not in limitation of other possible disclosures, disclose PHI for the following uses and purposes:

- to a doctor, hospital or pharmacist to assist them in providing treatment to a Participant;
- to investigate a complaint or process an appeal by a Participant;
- to a provider, a health care facility, or a health plan that is not a Business Associate that contacts the Plan with questions regarding the Participant's health care coverage;

- to bill the Participant for the appropriate charges and reconcile billings;
- as part of a program of fraud and abuse detection and prevention;
- to Business Associates to identify and contact Participants for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or treatment alternatives;
- in response to workers' compensation claims, a court or administrative order as permitted by law;
- for public health and safety reasons such as health research, preventing disease, helping product recalls, reporting suspected abuse, neglect or domestic violence or preventing or reducing a serious threat to health or safety;
- to evaluate performance of the Plan. Any such use would include restrictions for any other use of the information other than for the intended purpose;
- to comply with federal or state laws or orders from authorized federal and state law enforcement agencies and authorities or court orders;
- to respond to organ and tissue donation requests and work with a medical examiner or funeral director;
- to conduct an analysis of claims data. This information may be shared within the Plan Administrators or with Business Associates.

Section 10.4 Fund or Employer Certification The Fund and/or the Employer must:

a. Maintain the privacy and security of your Protected Health Information as required by law and follow the duties and privacy practices described in this Article and provide a copy upon request;

b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Fund or the Employer, as the case may be, with respect to such information;

c. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer nor use or share your information other than as described in this Article unless authorized by you in writing;

d. Promptly notify you if a breach occurs that may have comprised the privacy or security of your information;

e. Make available Protected Health Information in accordance with Federal medical privacy regulations;

f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with Federal medical privacy regulations;

g. Make available the information required to provide an accounting of disclosures in accordance with Federal medical privacy regulations and promptly advise you if a breach occurs that may have compromised the privacy or security of your information;

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Administrator available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with Article 10.

i. If feasible, return or destroy all Protected Health Information received from the Administrator that the Fund and/or the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which 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; and

j. Ensure that the Employer and the Administrator are adequately separated (as described in Section 10.5).

Section 10.5 Separation Between Administrator and Employer. Any employee or person who receives Protected Health Information relating to payment under, health care operation of, or other matters pertaining to the Plan in the ordinary course of business shall be restricted to the Plan Administration Functions that the Employer performs for the Plan.

Section 10.6 Employee Rights. As an employee, you have certain rights with respect to your health information. You have the rights to:

a. **Get a copy of your health and claims records.** You can ask to see or get a copy of your health and claims records and other health information which we have. We may charge a reasonable, cost-based fee to provide this information and will usually provide the information within 30 days.

b. **Ask us to correct health and claims records.** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may refuse your request but will provide a written explanation for the refusal within 60 days.

c. **Request confidential communications.** You can ask us to contact you in a specific way e.g. by mail to a specific address, or a call to a home or office phone. We will consider all reasonable requests and, if you inform us you would be in danger, we must say "yes".

d. **Ask us to limit what we use or share.** You can ask us to **not** use or share certain health information for treatment, payment or our operations. We are not required to agree to your request and may refuse it if it would affect your care.

i. If you have a clear preference for how we share your information, tell us what you want. You have the right to tell us to share information with your family, close friends or others involved in payment for your care or in the case of a disaster relief situation.

ii. In the event you cannot tell us your preference, e.g. you are unconscious, we may share your information if we believe it is in your best interest or if needed to lessen a serious and imminent threat to health or safety.

iii. We will not share your information, without your written permission, for marketing purposes or to sell your information.

e. **Get a list of those with whom we shared information.** You can ask for a list (accounting) of the times we have shared your health information, why and to whom for up to six (6) years prior to the date of the request. The list will include all disclosures other than for treatment, payment, health care operations and certain other disclosures. We will provide one accounting per 12-month period without charge; more frequent requests are subject to a reasonable, cost-based fee.

f. **Get a copy of this privacy notice.** You can ask for a paper copy of this information and/or HIPAA Privacy Notice at any time, even if you have agreed to receive the notice electronically. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htmi.

g. **Choose someone to act for you.** You can designate someone to exercise your rights and make choices about your health information either through a medical power of attorney or a legal guardianship appointment. We have the right to confirm that such person has been properly authorized to act for you before we take any action.

h. **File a complaint.** You can complain if you feel your rights have been violated. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-800-368-1019, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or contact the privacy official listed on Schedule A-1. We will not retaliate against you for filing a complaint.

Section 10.7 Mental Health Parity Act Requirements. The Fund is permitted to file an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services on an annual basis but has not done so for calendar year 2023. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Plan will be the same as for any other medical condition. Maximum annual and lifetime dollar limits for mental health benefits are set forth in the Plan. All health benefit plans offered through the Fund meet or exceed the federal requirements with respect to mental health parity. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Section 10.8 Certification of Coverage. HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this Plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A Certification of Coverage form, which verifies group health plan enrollment and termination dates, is available through the Employer's personnel office, in the event there is a termination of coverage.

Section 10.9 Special Enrollment Provisions and Children's Health Insurance Program. If you are eligible for health coverage from your employer but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

a. If you or your dependents are already enrolled in Medicaid or CHIP and you live in New Jersey or Pennsylvania, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

b. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

c. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA(3272).

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Programs.aspx
Phone: 1-800-692-7462

To see if other States have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

ARTICLE ELEVEN

Miscellaneous

Section 11.1 Public Health Service Act, non-ERISA Plan; Governing Law. Interpretation and administration of the Plan shall be governed by Federal law under the Public Health Service Act, consistent with other applicable Federal law; provided, however, that to the extent not preempted by Federal law, the Plan shall be governed as to any law governing personal property, legal death, decedent's estates, community property or related matters, by the laws of the state in which the person affected by such law is domiciled and as to all other matters, by the law of the State of New Jersey. If any provision of the Plan or the application thereof to any circumstance or person is invalid, the remainder of the Plan and the application of such provision to other circumstances or persons shall not be affected thereby.

Section 11.2 Family Medical Leave Act Coverage. Notwithstanding any other provision of the Plan to the contrary, a Participant who is on an authorized leave of absence under the Family Medical Leave Act of 1993 (FMLA), as amended, may continue participation in the Plan for up to 12 weeks (26 weeks in the case of certain military family leave entitlement). Such participation will be provided under the terms and conditions of the applicable Plan, including the rate of contributions that would have been applicable if the Participant had continued employment and subject to the terms and conditions of the FMLA policy of the Employer.

Section 11.3 Uniformed Services Employment and Reemployment Rights Act Coverage. Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

Section 11.4 Communication to Employees. The Employer will notify all Employees of the availability and terms of the Plan at least annually.

Section 11.5 Limitation of Rights. Neither the establishment of the Plan nor any Plan amendment will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, the Fund, or the Employer, except as expressly provided in the Plan, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

Section 11.6 Benefits Solely from General Assets. The benefits provided under this Plan will be paid solely from the general assets of the Employer and the Fund. No Plan provision will be construed to require the Fund, the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall

have any claim against, right to, or security or other interest in, any fund, account or asset of the Fund, the Employer or the Plan Administrator from which any payment under the Plan may be made.

Section 11.7 Mistaken Payment. If any payment is made by the Fund or/and the Employer because of a mistake of fact, the portion of that payment due to the mistake of fact shall be returned to the payor as permitted by applicable law.

Section 11.8 General Conditions of Plan All benefits described in the Plan are subject to the limitations and exclusions as set forth in the Plan. Payment for eligible services or supplies will be made under the Plan only under the following conditions: (i) are medically needed, as determined in the sole discretion of the Administrator, at the appropriate level of care (see below) for the medical condition; (ii) are a covered benefit; (iii) are ordered by an eligible provider for the diagnosis or treatment of illness or injury; (iv) were provided to a Participant; and (v) are not specifically excluded (listed in the "Exclusions").

a. The medical need and appropriate level of care for any service or supply is determined by the Administrator and is subject to the following requirements: (i) it is ordered by an eligible provider for the diagnosis or the treatment of an illness or injury; (ii) the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use; (iii) that it is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

b. The services and supplies provided under the Plan are sometimes referred to as "in-network benefits" and "out-of-network benefits". "In-network" care is provided through a network of providers which includes internists, general practitioners, pediatricians, specialists, and hospitals. Network providers offer a full range of services that include well-care and preventive services such as annual physicals, well-baby/well-childcare, immunizations, mammograms, annual gynecological examinations, and prostate examinations. "In-network" services, except as identified in the Plan Agreement, require no payments from a Participant in excess of the stated copayment or coinsurance amount. In-network hospital admissions, except as provided in this Agreement, require no copayment from a Covered Person. Hospitalization for in-patient mental health treatment are subject to certain specific conditions and copayments as set forth in the Plan.

c. If your health plan includes benefits for out-of-network services or supplies, and you choose to receive services or supplies from an out-of-network provider (doctor, other health care professional or facility) you generally will have to pay more out of pocket than if you used in-network doctors, health care professionals and/or facilities. **Out-of-network providers are not contractually obligated to accept the plan's payment as full payment and the provider may bill you for any balance of the billed charges.** The Administrator may use different sources to calculate the reimbursement rate for out-of-network services, including industry resources provided by entities such as ***FAIR Health*****,** the ***Centers for Medicare & Medicaid Services (CMS)***, and other databases. The Administrator uses these fee schedules to calculate a reimbursement allowance that corresponds to your plan's out-of-network benefits, taking into account your coinsurance, copayment, out-of-network deductible or any other member out-of-pocket costs applied to the claim. **IF YOU ARE PLANNING ON UTILIZING OUT OF NETWORK "OON' PROVIDERS WE WOULD RECOMMEND THAT YOU OR YOUR OON**

PROVIDER CONTACT THE ADMINISTRATOR TO OBTAIN A PRE DETERMINATION OF BENEFITS OR FOR INFORMATION ABOUT THE SPECIFIC REIMBURSEMENT METHOD OR FEE SCHEDULE FOR OUT-OF-NETWORK SERVICES FOR YOUR PLAN.

Section 11.9 Women's Health and Cancer Rights Act This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact the plan Administrator at the telephone number listed on Schedule A-1, attached hereto.

Section 11.10 Newborns' Act 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 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 and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Section 11.11 Patient Protection and Affordable Care Act Provisions The Patient Protection and Affordable Care Act ("ACA") mandates certain changes to health benefit plans. Among those changes is that effective for plan years beginning in 2011 adult children may be covered under their parent's health plan until age 26, without regard to marital, student or financial dependency status. While such adult children are eligible for coverage, their children, inclusive of new born and adopted children, are not eligible for coverage nor are their spouses. Under the ACA health plans must provide certain preventive care benefits, such as immunizations, age and gender appropriate screenings and well-baby care, without any cost sharing. However, this applies only when the services are delivered by an in-network provider and the preventive service is the primary reason for the office visit. In addition, other consumer protections within the ACA, for example, the elimination of lifetime limits on benefits, limits on out-of-pocket medical expenses and providing essential health benefits also apply to insured employer provided health plans. Questions regarding which protections apply and which protections do not apply to this health plan can be directed to your employer or to the Fund using the phone numbers provided at the end of this booklet.

If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-487-2365 or www.dol.gov/ebsa/consumer_info_health.html**. This web site has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal governmental plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.**

Section 11.12 Nondiscrimination and Accessibility Provisions The Fund and the Health Benefit Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Nor do they exclude people or treat them differently because of race, color, national origin, age, disability, or sex. When necessary, free

aids and services will be provided a permit people with disabilities to communicated effectively with us, such as qualified sign language interpreters, written information in large print, accessible electronic formats and other formats to facilitate reading and free language services such as qualified interpreters and translations of written text when your primary language is not English. If you need any of these services please contact your Employer's Human Resources or Benefits Manager. If you believe the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Program Manager at: : PERMA c/o Conner Strong Companies, Inc., Triad 1828 Centre, 2 Cooper Street, Camden, NJ 08102, mailing address P.O. Box 99106, Camden, NJ 08101; Telephone #: 856-552-4914; Fax #: 856-552-4919; e-mail: cbailey@connerstrong.com. If you need help filing a grievance Rachel Speer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 phone 1-800-368-1019; 800-537-7697(TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Section 11.13 Notice Regarding Wellness Program & Nondisclosure Your Employer may offer a Wellness Program. Any Wellness Program (hereinafter the "Program") is voluntary and available to all employees. The Program is administered in accordance with federal rules dealing with employer-sponsored wellness programs intended to improve employee health or prevent disease, including, but not limit to, the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable. Participants in the Program may be asked to complete a voluntary health risk assessment or "HRA" that contains questions about your health-related activities and behaviors and whether you have or have had certain medical conditions (e.g. cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening which will include a blood test for conditions such as high cholesterol or diabetes, among others. You are not required to complete an HRA or to participate in the blood test or other medical examinations. Employees who choose to participate in the Program may receive awards and prizes for achieving specific goals as outlined in the particular Program offered by your Employer and in which you choose to participate (see appropriate Program information for specifics). Additional incentives or prizes may be available to employees who participate in certain health-related activities such as exercise classes, walking, or other aerobic activities, or that achieve certain health outcomes, such as losing weight, reducing high cholesterol, high blood pressure, or diabetic tendencies. If you are unable, or believe you may be unable, to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Coach designated by your Employer. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Program. You are encouraged to share your results or concerns with your own doctor. The privacy and security of your personally identifiable health information is protected by law. Your Employer and the Program may use aggregate information collected to design a

wellness program based on identifiable health risks in the workplace. The Program will never disclose any of your personal information publicly or to your Employer except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Program, or as expressly permitted by law. No personally identifiable information provided in connection with the Program will be disclosed to your supervisors or managers or used to make employment decisions. Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Program and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Program or receiving an incentive. These conditions apply to anyone receiving your information associated with the Program and providing services to you. All medical information obtained through the Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Program will be used in making any employment decision. We will attempt to prevent any data breach and in the event a data breach occurs involving your personal health information, you will be notified immediately. You will not be discriminated against in employment based upon the medical information you provide as a participant in the Program nor will you be subjected to retaliation if you choose not to participate. If you have any questions or concerns regarding this notice or about protections against discrimination and retaliation, please contact your Employer's Director of Personnel.

SCHEDULE A

Health Benefit Plans Subject to this Supplemental Summary Plan Description

Group Health Plan

Plan 1: Aetna Choice POS II Open Access Plan, $10 PCP/Specialist Copay, Network Out-of-Pocket Maximum ("OOP Max") $400/$1,000
Plan 2: Aetna Choice POS II Open Access Plan, $15 PCP/Specialist Copay, Network OOP Max $400/$1,000
Plan 3: Aetna HMO Plan $10 PCP/Specialist Copay Plan, Network OOP Max $7,280/$14,560

Eligibility Requirements:

Plan 1-3: See Schedule A-1

Plan Effective Date: March 1, 2023

Group Prescription Drug Plan

Express Scripts, Inc. ESI National Preferred PSG Plans:
Plan 1: $3/$10/$10 retail; $0/$15/$15 mail order copay card
Plan 2: $6/$12/$24 retail; $5/$18/$30 mail order copay card
Plan 3: $10/$22/$44 retail; $5/$28/$55 mail order copay card

Eligibility Requirements:

See Schedule A-1

Plan Effective Date: March 1, 2023

SCHEDULE A-1

Aetna Choice POS II & HMO Medical Plans & Express Scripts $3/$10/$10, $6/$12/$24, & $10/$22/$44 copay plans

I. GENERAL INFORMATION

a. NAME AND ADDRESS OF EMPLOYER: Township of Delran, 900 Chester Avenue, Delran, NJ 08075

b. TYPE OF AGREEMENT:
Medical Benefit Plans:
Plan 1: Aetna Choice POS II Open Access Plan, $10 PCP/Specialist Copay, Network Out-of-Pocket Maximum ("OOP Max") $400/$1,000
Plan 2: Aetna Choice POS II Open Access Plan, $15 PCP/Specialist Copay, Network OOP Max $400/$1,000
Plan 3: Aetna HMO Plan $10 PCP/Specialist Copay Plan, Network OOP Max $7,280/$14,560

Group Prescription Drug Plan:
Express Scripts, Inc. ESI National Preferred PSG Plans:
Plan 1: $3/$10/$10 retail; $0/$15/$15 mail order copay card
Plan 2: $6/$12/$24 retail; $5/$18/$30 mail order copay card
Plan 3: $10/$22/$44 retail; $5/$28/$55 mail order copay card

c. THE NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE ADMINISTRATOR: Medical Plan: *Aetna Life Insurance Company 8000 Midlantic Drive, Suite 100 North, Mt. Laurel, NJ 08054; Phone # 1-800-370-4526*

Prescription Plan: *Express Scripts, Inc. P.O. Box 390873, Bloomington, MN 55439-0873; Phone # 1-800-282-2881*

Privacy Official: *Rachel Speer, Township of Delran, see above*

d. AGREEMENT EFFECTIVE DATE: See Schedule A

e. WAITING PERIOD: Actively Working Eligible Employees; Eligible for Benefits:
X Effective after sixty (60) days of employment.

f. ELIGIBLE EMPLOYEE: X Full-time active Employee working not less than 35 hours per week for 12 months per year.

g. ELIGIBLE DEPENDENTS: X Spouse meaning a member of the opposite sex to whom the employee or retiree is legally married and who is not divorced, divorced from bed and board, legally separated or had an annulment of the marriage to the Employee. Proof of marriage is required for enrollment.

X Civil Union Partner, meaning a member of the same sex with whom the employee has entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment.

X Eligible children under age 26 whether or not living with the employee, inclusive of those away at school, and without regard to marital or financial dependency status and without regard to whether they are eligible to enroll in other employer based health coverage (other than through a parent). If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible. Appropriate documentation are required with enrollment forms for step-children, adopted children, foster children and in guardian/ward cases. Children of eligible children, including newborns, and adopted children of said eligible children are not *eligible for coverage.*

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, the health plan of the parent named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and an Enrollment Application submitted electing coverage for the child within 60-days of the date the order was issued. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with the employee and are substantially dependent upon the employee for support and maintenance. Affidavits of Dependency and legal documentation are required with enrollment forms for these cases.

Medical, and prescription coverage for children ends on the December 31st of the year in which they attain age 26.

X Dependents with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage. To request continued coverage, ask your Employer for a Continuance for Dependent with Disabilities form. The form and proof of the child's condition must be given to the Employer no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the Continuance for Dependent with Disabilities form. Coverage for children with disabilities may continue only while (1) the Eligible Employee is covered under this Agreement, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on the Eligible Employee for support and maintenance. Periodic verification that the child remains eligible for continued coverage is required.

X Over Age Children to Age 31 — Certain over age children may be eligible for coverage until age 30 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. An over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered Eligible Employee has selected. The covered Eligible Employee is responsible for the entire cost of coverage. There is no provision for eligibility for dental or vision

benefits. An enrolled over age child will no longer be covered when the child does not satisfy any one, or more, of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered Eligible Employee's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of non-payment.

h. ELIGBIBLE RETIREES meaning former Eligible Employees who satisfy the following requirements:

X Retired with 25 years or more of service for all employees other than police. No minimum service requirement for police but subject to the conditions set forth in the applicable negotiated contract.

EXHIBIT "I"

Health Benefit Plans for Township of Delran

Aetna Choice POS II Plan Descriptions

Aetna HMO Plan Description

Express Scripts Prescription Drug Plan Summary Plan Description

EXHIBIT "II"

Schedules of Benefits

Aetna:
Plan 1: Aetna Choice POS II Open Access Plan, $10 PCP/Specialist Copay, Network Out-of-Pocket Maximum ("OOP Max") $400/$1,000, Summary of Benefits & Coverage ("SBC") attached
Plan 2: Aetna Choice POS II Open Access Plan, $15 PCP/Specialist Copay, Network OOP Max $400/$1,000, SBC attached
Plan 3: Aetna HMO Plan $10 PCP/Specialist Copay Plan, Network OOP Max $7,280/$14,560, SBC attached

Express Scripts: See Express Scripts Summary Plan Description