# FIRST AMENDMENT TO
# MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND
# HEALTH CARE CHOICE PLAN
## (As Amended and Restated Effective January 1, 2004)

**1. Effective January 1, 2011, the preamble to the Plan is amended to read as follows:**

*"HEALTH CARE PLANS*

In order to provide cost effective medical benefits to all eligible participants of the "Local Units" of Government in Middlesex County, an Agency called Middlesex County Joint Health Insurance Fund ("Fund") was created. The Fund's purpose is to provide health care benefits to all eligible participants for Medically Necessary services covered under this Plan. This booklet details, in general, what Covered Persons must do to apply and receive these benefits.

In order to provide for efficient processing of health care claims, effective January 1st, 2003, the Fund uses Horizon Blue Cross Blue Shield of New Jersey. In brief, if a Covered Person needs to claim benefits, a Covered Person begins by contacting the person who has been designated to handle the benefits in this Local Unit of Government. This person will provide a Covered Person with the necessary claim forms which must be completed by the Covered Person and the Attending Physician. These forms must be submitted to Horizon Blue Cross Blue Shield of New Jersey as described in the appropriate section of this booklet called "How to Submit a Claim." Please be aware, in order to be eligible to receive a benefit payment or reimbursement under this Health Care Choice Plan (the "Plan"), a Covered Person must include with the completed claim form itemized bills that adequately describe all the services rendered.

This booklet sets forth the general coverage provided under the Plan. A Covered Person is entitled to this coverage if the Covered Person is eligible in accordance with this plan document (the "Plan Document"). This booklet is void if the Covered Person has ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force.

**Note that specific personnel policies may affect the provisions described in this Plan Document. Please contact your Personnel Department for more information.**

**Notwithstanding any other provisions of the Plan, this Plan will duplicate, in the scope and dollar amount each and every health care coverage that was provided to each Employee, Retiree, Dependent, or COBRA participant by the health care policy applicable to said persons at the time of the inception of this Plan.**

This Plan shall also provide, contrary or more effective language notwithstanding, those coverages which the statutes and administrative regulations of the State of New Jersey require a Local Unit of Government, member of the Middlesex County Joint Health

Insurance Fund to provide to an Employee, Retiree, Dependent or COBRA participant as the case may be.

The Fund intends this Plan to constitute a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan is not legally required to adopt certain provisions of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Grandfathered health plans must comply with certain other provisions in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose its grandfathered health plan status can be directed to the Fund Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov."

**2. Effective January 1, 2011, Section I, General Information, as it relates to Dependent Children's Coverage, is amended to read as follows:**

"COVERAGE FOR CHILDREN:

**Medical Coverage:** A child may be covered from birth through the last day of the Calendar Year in which the child attains the age of twenty-six (26)."

**3. Effective January 1, 2011, Section II, Eligibility, as it relates to Eligible Classes of Dependents, is amended to read as follows:**

"**(2) A covered Employee's Child(ren)**

**Medical Coverage:** A child of a covered Employee is eligible for medical coverage until such child reaches the limiting age of twenty-six (26) years (the "Limiting Age"). However, if such child is eligible to enroll in other employer-sponsored health coverage, he or she may not be eligible for coverage under this Plan until this Plan is no longer considered a "grandfathered health plan" as defined under the Affordable Care Act or January 1, 2014, whichever occurs first. Upon reaching the Limiting Age, coverage for medical benefits will terminate on the last day of the Calendar Year.

The term "children" or "child" shall include natural children, step children, adopted children, foster children, children placed with a covered Employee in anticipation of adoption or unmarried children for whom the covered Employee is the Legal Guardian.

The phrase *"child placed with a covered Employee in anticipation of adoption"* refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption.

The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Coverage of these pre-adoptive children is required by the federal Omnibus Budget Reconciliation Act of 1993 and no Pre-Existing Conditions provisions, if any, are applied to this coverage. The child must be available for adoption and the legal process must have been commenced.

The Plan Administrator may require documentation proving child eligibility, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993, and no Pre-Existing Conditions provisions, if any, are applied to this coverage. This Plan's qualified medical child support order procedures are available upon request.

(3) **A covered child who is Totally Disabled.** A covered child who is incapable of self-sustaining employment by reason of mental illness, mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under this Plan when reaching the Limiting Age may be covered under this Plan beyond the Limiting Age. The Plan Administrator may require, at reasonable intervals during the two (2) years following the child's reaching the Limiting Age, subsequent proof of the child's disability and dependency.

After such two (2) year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such child examined by a Physician of the Plan Administrator's choice, at this Plan's expense, to determine the existence of such incapacity."

**4. Effective January 1, 2011, Section II, Termination of Coverage, as it relates to When Dependent Coverage Terminates, is amended to read as follows:**

"(7) The last day of the Calendar Year in which a covered child attains age twenty-six (26).

**5. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Maximum Benefit Amounts, is amended to read as follows:**

**"MAXIMUM BENEFIT AMOUNTS FOR ESSENTIAL BENEFITS**

| | |
|---|---|
| Lifetime, while covered: | |
| In-Network | Unlimited |
| Out-of-Network | Unlimited (effective 1/1/2011) |

**MAXIMUM BENEFIT AMOUNTS FOR NON-ESSENTIAL BENEFITS**

| | |
|---|---|
| Lifetime, while covered: | |
| In-Network | Unlimited |
| Out-of-Network | $1,000,000" |

**6. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Mental Disorders and Substance Abuse *(Drug Related)* Treatment Limits, is amended to read as follows:**

"**Mental Disorders and Substance Abuse (*Drug Related*) Treatment Limits** ***(Precertification required for Inpatient only)***

| | |
|---|---|
| Inpatient percentage payable: | |
| Network Providers | Twenty-five (25) days per Calendar Year covered at 100%; balance at 90% |
| Non-network Providers | 80% after deductible |
| Inpatient Physician care percentage payable: | |
| Network Providers | Twenty-five (25) days per Calendar Year covered at 100%; balance at 90% |
| Non-network Providers | 80% after deductible |
| **Partial Hospitalization (*Day Care*)*** | |
| Percentage payable: | |
| Network Providers | Balance of remaining inpatient days at 100% |
| Non-network Providers | Balance of remaining inpatient days at 80% after deductible |

***Note: Unused inpatient days may be exchanged for Partial Hospitalization visits on a two-for-one basis. (One (1) inpatient day equals two (2) Partial Hospitalization visits). Day Care is care in an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period.**

**Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)**

| | |
|---|---|
| Outpatient percentage payable: | |
| Network Providers | 100% after applicable copayment |
| Non-network Providers | 80% after deductible" |

**7. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Alcoholism Treatment Limits, is amended to read as follows:**

"**Alcoholism Treatment Limits (*Precertification required for Inpatient only)***
Inpatient percentage payable:

| | |
|---|---|
| Network Providers | 100% |
| Non-network Providers | 80% after deductible |
| | |
| Outpatient percentage payable: | |
| Network Providers | 100% after applicable copayment |
| Non-network Providers | 80% after deductible" |

**8. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Detoxification and Residential Facility, is amended to read as follows:**

"**Detoxification and Residential Facility (*Precertification required*)**

| | |
|---|---|
| Percentage Payable: | |
| Network Providers | 100% |
| Non-network Providers | 80% after deductible |

**Note: Precertification required. Any and all services which require precertification and are not precertified or authorized will result in a reduction of the benefits payable. (Refer to the Cost Management section of this Plan.)"**

**9. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Organ Transplant Coverage Limits, is amended to read as follows:**

"**Organ Transplant Coverage Limits (*Precertification and prior authorization required)***

Covered Transplant Procedures:

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational."

| | |
|---|---|
| Percentage Payable: | |
| Network Providers | 100% |
| Non-network Providers | 80% after deductible |
| | |
| Transplant Lifetime Maximum Benefit | Subject to this Plan's maximum benefit amount for non-essential benefits |
| | |
| Donor coverage maximum | Subject to the Transplant Lifetime Maximum Benefit" |

**10. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Preventive Care (*Routine Well Adult Care*), is amended to read as follows:**

"**Preventive Care *(Routine Well Adult Care)***

| | |
|---|---|
| Percentage payable: | |
| Network Providers | 100% after applicable Copayment[2] |

| | |
|---|---|
| Non-network Providers | **NOT COVERED** |

Coverage includes reimbursement for the following routine services: pap smear, mammography, prostate screening, gynecological and routine physical examination, related x-rays, laboratory tests, hearing screening and immunizations.

[12]In the event this Plan is no longer considered a grandfathered health plan under the Affordable Care Act, copayments on certain types of preventive care will not be required."

**11. Effective January 1, 2011, Section III, Health Care Choices Plan (Plan B) Schedule of Benefits, as it relates to Preventive Care (*Routine Well Child Care*), is amended to read as follows:**

"**Preventive Care *(Routine Well Child Care)***

| | |
|---|---|
| Percentage payable: | |
| Network Providers | 100% after applicable copayment* [12] |
| Non-network Providers | 80% after deductible** |

***Note: In-network coverage includes payment for the following routine services: routine physical examinations, related x-rays, laboratory tests and immunizations.**

****Note:Out-of-network coverage includes payment for the following routine services: injections, immunizations, diagnostic x-rays, laboratory tests and other testing, physical and speech therapy for covered children less than twelve (12) months of age. No coverage is provided for periodic physical exams, immunizations or other routine preventive and wellcare services for Covered Persons over twelve (12) months of age.**

[12] In the event this Plan is no longer considered a grandfathered health plan under the Affordable Care Act, copayments on certain types of preventive care will not be required."

**12. Effective January 1, 2011, Section III, Benefit Summary – Health Care Choices Plan (Plan B), as it relates to Deductibles, Coverage & Coinsurance, Out of Pocket Maximums and Individual Lifetime Maximums, is amended to read as follows:**

| BENEFIT DESIGN | PROVISIONS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **DEDUCTIBLE:** Per Calendar Year** | • Per Covered Person | NONE | $100** |
| | Per Covered Family Unit (cumulative) | NONE | $200** |
| **COVERAGE & COINSURANCE** | • Plan pays | 100%; or 90% where applicable | 80% of $2,000; then 100% |
| | • Covered Person pays | Applicable Copayment; or 10% where applicable | 20% of $2,000 |
| **OUT OF POCKET MAXIMUM** Per Calendar Year | • Per Covered Person<br>• Per Covered Family Unit (cumulative) EXCLUDING DEDUCTIBLES where applicable | When annual coinsurance payments (out-of-pocket) equals $300 per Covered Individual / $600 per Covered Family Unit, then the 100% benefit provision will apply for all eligible covered expenses for all eligible Covered Persons in the Covered Family Unit for the balance of that Calendar Year | When annual coinsurance payments (out-of-pocket) equals $400 per Covered Individual / $800 per Covered Family Unit, then the 100% benefit provision will apply for all eligible covered expenses for all eligible Covered Persons in the Covered Family Unit for the balance of that Calendar Year |
| **INDIVIDUAL LIFETIME MAXIMUM** | • Per Covered Person | Unlimited | Unlimited [b] |

**NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.**

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

** **Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Family Unit per Calendar Year (cumulative)

[b] There is a $1,000,000 individual lifetime maximum for out-of-network care for non-essential benefits

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

**@ Certification Required – Non Compliance Penalty** – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

**13. Effective January 1, 2011, Section III, Benefit Summary – Health Care Choice Plan (Plan B), as it relates to Preventive Care and Physician Services, is amended to read as follows:**

| BENEFIT DESIGN | PROVISIONS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **PREVENTIVE CARE**<br><br>**See #NOTE below**<br><br>* NOT COVERED or Limited for Out-of-Network Benefits | • **Adult Routine Physical Exams* and Including**<br><br>• Related X-ray/ Laboratory tests*<br>• Well Woman Exam*<br>• Pap Smear*#<br>• Mammography*#<br>• Immunizations*<br>• Prostate Screening*<br>• Hearing Screening*<br><br>• **Well Child Care* Including**<br><br>• Routine Physicals*<br>• Related X-ray Laboratory tests<br>• Immunizations* | $5 Copayment[6]; Then 100% Coverage | NOT COVERED<br><br>Deductibles apply**<br>80% Coverage;<br>20% Coinsurance are provided for injections, immunizations, diagnostic x-ray/ laboratory, physical therapy, speech therapy for children not less than twelve (12) months old. No coverage is provided for periodic physical exams, pap smears, immunizations or well care for Covered Persons over twelve (12) months old. |
| **PHYSICIAN SERVICES** | • Inpatient Visits<br>• Surgical Services @<br>• Anesthesia<br>• Assistant Surgeon<br>• Nursery, Well Newborn Care<br><br>• Physicians/Specialist<br>• Home/Office Visits<br>• Chiropractic Visits and other Services<br>• Periodic review of Treatment Plan and medical care required to determine Medical Necessity and<br>• Appropriateness of continued care | 100% Coverage<br><br>$5 Copayment; then 100% Coverage | Deductibles apply**<br>80% Coverage;<br>20% Coinsurance<br><br>Deductibles apply**<br>80% Coverage;<br>20% Coinsurance |

**NOTE: Non-Referred IN-NETWORK services will be treated as OUT-OF-NETWORK services, subject to all the provisions of the Out-of-Network Plan.**

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

** **Deductibles:** $100 per Covered Person per Calendar Year
$200 per Covered Person per Calendar Year (cumulative)

[15] In the event this Plan is no longer considered a grandfathered health plan under the Affordable Care Act, copayments on certain types of preventive care will not be required.

**#NOTE:** Preventive Care – the following is limited to:
Routine Pap Smear: one (1) per Calendar Year
Mammography: Ages 35-39: *one (1) baseline*
Ages 40-49: *one (1) every two (2) years*
Ages 50 & over: *one (1) annually*
Prostate Screening: Age 40 & over with family history: *one (1) annually*
Age 50 & over: *one (1) annually*

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

**@ Certification Required – Non Compliance Penalty** – In or Out-of-Network – Inpatient Admissions / Surgical Procedures and other services noted with an "@" are not precertified or authorized will be subject to a reduction in benefits. This reduction will be 20% of what would otherwise be payable to a maximum of an additional $2,000 out-of-pocket cost per Covered Person per Calendar Year, not including the Plan deductible and coinsurance.

**14. Effective January 1, 2011, Section III, Benefit Summary – Health Care Choice Plan (Plan B), as it relates to Inpatient Mental Disorders & Substance Abuse Services (*Drug Related*), Inpatient Substance Abuse (*Alcoholism Only*), and Mental Disorders & Substance Abuse (*Drug Related*), is amended to read as follows:**

| BENEFIT DESIGN | PROVISIONS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **INPATIENT MENTAL DISORDERS & SUBSTANCE ABUSE SERVICES (*Drug Related*) @**<br>• **IMPORTANT**: Partial Hospitalization (*Day Care*) must be pre-authorized. Unused Inpatient Days may be exchanged for Partial Hospitalization Visits on a two-for-one basis. (One (1) Inpatient Day equals two (2) Partial Hospitalization Visits). | • Day limits per Calendar Year @ 100%<br>• Day Care is an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period | Twenty-five (25) Days Covered at 100%; balance at 90% Coverage with 10% Coinsurance | Deductibles apply**<br>80% Coverage;<br>20% Coinsurance |
| **INPATIENT SUBSTANCE ABUSE** (*Alcoholism Only*) | • All Hospital provided services covered on the same basis as any other medical condition | 100% Coverage | Deductibles apply**<br>80% Coverage;<br>20% Coinsurance |
| **MENTAL DISORDERS & SUBSTANCE ABUSE (*Drug Related*)@**<br>• Related Care in an Intermediate Care Facility | • See Inpatient for provisions and limitations | Twenty-five (25) Days Covered at 100%; balance at 90% Coverage with 10% Coinsurance | Deductibles apply**<br>80% Coverage;<br>20% Coinsurance |

| | | | |
|---|---|---|---|
| • **IMPORTANT:** Partial Hospitalization (*Day Care*) must be pre-authorized. Unused In-patient Days may be exchanged for Partial Hospitalization Visits on a two-for-one basis. (One (1) Inpatient Day equals two (2) Partial Hospitalization Visits). | | | |

**15. Effective January 1, 2011, Section III, Benefit Summary – Health Care Choice Plan (Plan B), as it relates to Outpatient Mental Disorders & Substance Abuse (*Drug Related*), Outpatient Substance Abuse (*Alcohol Related*) and Maximum Benefits Mental Disorders & Substance Abuse (*Drug Related*), is amended to read as follows:**

| BENEFIT DESIGN | PROVISIONS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **OUTPATIENT MENTAL DISORDERS & SUBSTANCE ABUSE *(Drug Related)*** | • Copayment applies per Visit | $5 Copayment; then 100% Coverage | Deductibles apply** 80% Coverage; 20% Coinsurance |
| **OUTPATIENT SUBSTANCE ABUSE *(Alcohol Related)*** | • Copayment applies per Visit<br>• Covered on the same basis as any other medical condition | $5 Copayment; then 100% Coverage | Deductibles apply** 80% Coverage; 20% Coinsurance |

**16. Effective January 1, 2011, Section IV, Medical Benefits, as it relates to Treatment of Mental Disorders and Substance Abuse (*Drug Related*), is amended to read as follows:**

"**TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE *(DRUG RELATED)***

Covered charges for care and treatment of Mental Disorders and Substance Abuse *(Drug Related)* will be limited as follows:

(1) Physician's visits are limited to one (1) treatment per day.

(2) Psychiatrists (M.D.), Psychologists (Ph.D.) or Counselors (Ph.D.) may bill this Plan directly. Other licensed mental health practitioners permitted by statute or regulation to bill directly may do so. All other mental health professionals must bill this Plan through these professionals.

(3) Partial Hospitalization *(Day Care)* visits by exchanging unused inpatient days for Partial Hospitalization visits on a two-for-one basis. Day Care is the care in an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period."

**17. Effective January 1, 2011, Section IV, Plan Exclusions is amended to read as follows:**

"**(28) Routine care.** Charges for routine or periodic physical examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or is required under the Affordable Care Act."

**18. Effective January 1, 2011, Section VII, COBRA Continuation Options is amended to read as follows:**

"**COBRA CONTINUATION OPTIONS**

**Introduction**

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator (who is responsible for administering COBRA continuation coverage) to Plan Participants who become eligible for COBRA continuation coverage

**COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse.

Your children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. They are no longer considered eligible dependents under the terms of the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a child who is no longer considered an eligible dependent under the terms of the Plan), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must also complete a universal benefits form and submit such form to the Personnel Department within 60 days after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a child losing his or her eligibility for coverage under the Plan, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to18 months.

As explained below, there are two ways in which this 18-month period of COBRA continuation coverage can be extended:

(1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the COBRA Administrator.

(2) Second qualifying event: extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a child when the child is no longer considered an eligible dependent under the terms of the Plan. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator.

**If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator.

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator."

**IN WITNESS WHEREOF**, the Middlesex County Joint Health Insurance Fund has caused this First Amendment to be executed this 21ST day of DECEMBER, 2010.

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

Signed: Samuel M Kikla

Name: Samuel M Kikla

Title: Executive Director

**Effective January 1, 2011, Section I, Summary Plan Description, General Information,** the following changes have been made:

| | |
|---|---|
| PLAN PROGRAM MANAGER:<br>Effective April 1, 2010 | Business & Governmental Insurance Agency<br>Plaza Nine, 900 Route 9 North, Suite 503<br>Woodbridge, NJ 07095-1003 |
| AGENT FOR SERVICE OF LEGAL PROCESS:<br>Effective January 1, 2011 | Middlesex County Joint Health Insurance Fund<br>c/o Patrick J. Diegnan, Jr, Esq.<br>P.O. Box 376<br>2443 Plainfield Avenue<br>South Plainfield, NJ 07080 |
| FUND ATTORNEY AND PRIVACY OFFICER<br>Effective January 1, 2011 | Patrick J. Diegnan, Jr, Esq.<br>P.O. Box 376<br>2443 Plainfield Avenue<br>South Plainfield, NJ 07080 |