SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

SUPPLEMENTAL SUMMARY PLAN DESCRIPTION

FOR:

RIVERSIDE TOWNSHIP BOARD OF EDUCATION

HEALTH BENEFIT PLANS

2010

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SUPPLEMENTAL SUMMARY PLAN DESCRIPTION FOR:

RIVERSIDE TOWNSHIP BOARD OF EDUCATION

HEALTH BENEFIT PLANS

Introduction

This is the Supplemental Summary Plan Description for the health benefit plans (medical) provided by the Riverside Township Board of Education (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, Boards of Education and other Local Units eligible to participate in a joint insurance fund who have elected to participate in the Fund (the "Member" or collectively "Members") in order 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") (Aetna is sometimes hereinafter referred to 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.

This Supplemental Summary Plan Description ("SSPD"), and the attachments, exhibits and schedules attached to this SSPD and incorporated herein by reference outline the services and benefits and other rights and privileges which are available to eligible employees and their dependents. Every effort has been made to ensure the accuracy of this SSPD, which describes eligibility for and the medical benefits (sometimes referred to as "health benefits") provided through the Fund. The Fund is subject to New Jersey State law and regulations. In the event there are inconsistencies or discrepancies between the information presented in this SSPD and/or plan documents and the laws, regulations, or contracts governing the Fund, the latter will govern.

The rights and conditions with respect to the benefits payable by the Administrator for the benefits to be provided under the Health Benefit Plan shall be determined by the Administrator in accordance with the their agreement with the Fund and their contracts with service providers, the terms of which are incorporated herein by reference. In the event of a conflict between the terms of this SSPD and the terms and conditions of the agreements with the Administrator, the terms of the Administrator's agreements shall control. Your Employer establishes the criteria for

determining the persons eligible for coverage under the Health Benefit Plan, the dates of their eligibility, and the benefits Participants are entitled to receive and the circumstances under which their eligibility terminates.

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 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 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. 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 an unmarried 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, 2010. 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 Riverside Township Board of Education.

Health Benefit Plan means the specific health or medical benefit arrangement identified in Schedule A under which the Employer provides health and medical 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 Patriot V QPOS Plan, the Aetna Patriot X QPOS Plan and the Aetna Premier QPOS 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 who will perform its duties and responsibilities as detailed in this document or the documents of the 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 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.

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.

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 age 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. 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. 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. (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 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 with full power to interpret and apply the terms of the 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.

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 Spouse, his 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 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 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's Executive Committee and, at the Participant's written request, the appeal may be made with the identity of the Participant revealed. 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. The Participant may appeal an adverse determination concerning a claim to the Executive Committee by forwarding a copy of the determination letter issued by the Administrator to the Fund's Program Manager, who shall place it on the agenda for a closed session discussion at the next regularly scheduled meeting of the Fund, unless the appeal is received seven (7) business days or fewer prior to the next meeting, in which case it shall be placed on the ensuing meeting agenda. Prior to distribution of any writing concerning the appeal, all references to the Participant or the Employer shall be stricken, unless the Participant has requested in writing that their identity be revealed. The Fund's Program Manager shall review the claim and make a written recommendation to the Executive Committee prior to their deliberation regarding same. Whenever practical, the Executive Committee shall render its decision upon conclusion of the discussion at the appeal meeting, and if the Participant is not present, advise the Participant in writing of the determination and the reasons therefore within five (5) business days.

b. If the Participant is dissatisfied with the Executive Committee's determination, the Participant may appeal the Executive Committee's determination to the independent appeal organization designated by the Fund annually for a non-binding determination pursuant to fair, informal procedures adopted from time to time.

. c. If the Participant is dissatisfied with the determination of the independent appeal agency, the Participant may exercise any remedies provided by law.

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.

ARTICLE EIGHT

Subrogation and Right of Recovery

Section 8.1. Definitions. As used throughout this provision, the term "Responsible Party" means any party actually, 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. Effective for plan years beginning on and after January 1, 2009, 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 Failure to Elect 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.

a. First, the qualified beneficiary can lose the right to avoid having pre-existing condition exclusions applied to him/her by other group health plans if the qualified beneficiary has more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help the qualified beneficiary to bridge such a gap. (If, after enrolling in COBRA the qualified beneficiary obtains new coverage which has a pre-existing condition clause, he/she may continue their COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)

b. Second, the qualified beneficiary will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if he/she does not continue coverage under COBRA for the maximum available time.

c. Finally, a qualified beneficiary has special enrollment rights under federal law. A qualified beneficiary has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by his/her spouse's employer) within 30 days of the date his/her group coverage ends. The qualified beneficiary will also have the same special enrollment right at the end of the COBRA coverage period if he/she gets the continuation of coverage under COBRA for the maximum available time.

Section 9.3 Subsidy for Qualified Beneficiaries. The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, allows certain employees whose employment was

involuntarily terminated between September 1, 2008 and May 31, 2010 to receive a subsidy for the cost of the COBRA coverage they have elected provided that a qualified employee pays thirty-five (35%) percent of the cost of the COBRA coverage elected. The maximum period for this COBRA subsidy is fifteen (15) months, for periods of coverage beginning on or after February 17, 2009, although the period for COBRA coverage may be more than fifteen (15) months. Your Employer is required to provide notice of this subsidy and the election rights available to qualified employees.

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.

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 to the Employer or to provide for or permit the disclosure of Protected Health Information to the Employer by a health insurance carrier with respect to the Plan, shall restrict uses and disclosures of such information by the Employer 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:

(i) disclose Protected Health Information to the Fund or the Employer to carry out Plan Administration Functions that the Employer performs to the extent consistent with the provisions of this Article 10;

(ii) not disclose and may not permit a health benefit plan to disclose Protected Health Information to the Fund or the Employer as otherwise permitted by this Article 10 unless a statement to that effect is included in the appropriate notice of privacy practices; and

(iii) not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer, except as permitted by law.

(iv) 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 a court or administrative order as permitted by law;
- 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 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. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

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;

d. If it becomes aware, report to the Administrator any use or disclosure of information that is not consistent with the procedures outlined in the Plan;

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;

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 Mental Health Parity Act Requirements. The Fund has filed an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services for calendar year 2009 and is expected to file an exemption for calendar year 2010. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Plan will not change, with an exception for biologically-based mental illness. 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 the exception of mental health parity for this Plan. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Section 10.7 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, should there be a termination of coverage.

Section 10.8 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 a 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**.

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

To see if other States have added a premium assistance program since March 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, 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, descendents 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-child care, 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.

SCHEDULE A

Health Benefit Plans Subject to this Supplemental Summary Plan Description

Group Health Plan

Plan 1: Aetna Patriot V QPOS Plan
Plan 2: Aetna Patriot X QPOS Plan
Plan 3: Aetna Premier QPOS Plan

Eligibility Requirements:

Plan 1 through 3: See Schedule A-1
Plan Effective Date: July 1, 2009

SCHEDULE A-1

Aetna Patriot V QPOS, Patriot X QPOS & Premier QPOS Medical Plans

I. GENERAL INFORMATION

a. AGREEMENT NUMBER: SNJEBF # 727871

b. NAME AND ADDRESS OF EMPLOYER: Riverside Township Board of Education 112 E. Washington Street, Riverside, NJ 08075

c. TYPE OF AGREEMENT:

Medical Benefit Plan 1: Aetna Patriot V QPOS Plan
Medical Benefit Plan 2: Aetna Patriot X QPOS Plan
Medical Benefit Plan 3*:* Aetna Premier QPOS Plan

d. 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*

e. AGREEMENT EFFECTIVE DATE: July 1, 2007

f. WAITING PERIOD: Actively Working Eligible Employees; Eligible for Benefits:

X Immediately if employed on the Effective Date.

X First day following two months of continuous employment if not employed on the Effective Date (For example if you start work on September 15 your coverage will be effective November 15. If you have an annual contract and are paid on a 10 month basis and begin work at the start of the contract year, your coverage will be effective on September 1.)

g. ELIGIBLE EMPLOYEE: X Full-time active Employee meaning one who is working not less than 20 hours per week for the regularly scheduled work period (12 months or 10 month school year inclusive of ambulatory aides hired after September 1, 2007.

i. 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 certificate from another jurisdiction that recognizes same-sex civil unions is required for enrollment.

X Eligible unmarried children under age 23 living with the employee in a regular parent-child relationship, inclusive of those away at school, as well as divorced children living at home provided that they are dependent upon the employee for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Affidavits of Dependency and legal documentation are required with enrollment forms for these cases.

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.

Coverage for an enrolled child will end when the child marries, enters into a civil union or domestic partnership, moves out of the household, turns age 23, or is no longer dependent on the employee for support and maintenance. Coverage for children ends on December 31 of the year in which they attain the limiting age (i.e. 23).

X Dependents with Disabilities — If a child is not capable of self-support when he or she reaches age 19 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 19, 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 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.