GROUP DENTAL INSURANCE

Horizon BRONZE (Dental Choice Plan)

A Partnership "TOTAL REWARDS" Program

Meridian Health
GRP # 96194-35, 45, 46

COVERAGE PROVIDED BY
YOUR GROUP'S DENTAL POLICY WITH

HORIZON HEALTHCARE
DENTAL, INC.

In this Evidence of Coverage, You will find the important features of Your Group Dental coverage.

This Evidence of Coverage is only a general description of Your benefits. The Policy issued to Your Group by Horizon Healthcare Dental, Inc. contains all the terms and provisions of the Contract between the Group and Horizon Healthcare Dental, Inc. In the event of a conflict between the Policy and this Evidence of Coverage, the Policy will prevail.

IMPORTANT NOTICE

In order to be eligible, the Covered Services provided must be Necessary and Appropriate Dental Services and must be rendered by Your Primary Care Dentist or authorized by Us to be provided by a Specialty Care Dentist, except for Emergency Services. Non-Emergency Out-of-Network Services are not Covered Services.

You may be responsible for Coinsurance for some Covered Services.

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GENERAL INFORMATION

A. SUBSCRIBERS

All Employees in any Eligibility Classification(s) below may be covered by the Policy. Each of them and their Dependents are eligible for coverage under the Policy as stated in Section B if, on or after the Effective Date, the Employees has completed the appropriate Waiting Period, if any, and has, along with any Dependents, satisfied the Underwriting Requirements, as Determined by Horizon Healthcare Dental, Inc. (Horizon).

B. ELIGIBILITY CLASSIFICATION(s)

All regular Active, Full-Time/Part-Time Employees who reside in the State of New Jersey and are not covered under any other Alternate Dental Plan offered by the Group.

C. WAITING PERIOD

Coverage shall be effective for eligible Employees on the later of the Effective Date or on the 1st of the month following hire date. However, coverage for rehired Employees shall be effective from the later of the Effective Date or same as new.

D. THE HORIZON DENTAL CHOICE NETWORK

Horizon Healthcare Dental, Inc. administers a network of Primary Care Dentists and provides access to Specialty Care Dentists, collectively referred to as the Horizon Dental Choice Network ("Horizon Network"), to provide Covered Services to Members. Coverage is subject to the exclusions, limitations, conditions and other terms of Your Policy.

Services are provided through the Horizon Network. You and each of Your Dependents must choose a Primary Care Dentist from a list provided by Horizon, A choice of a Primary Care Dentist may be changed effective on the first day of the following month. To do so, the Member must give Horizon written notice of such change at least 15 days in advance.

For certain dental care, the Primary Care Dentist may recommend, subject to Horizon's approval, care by a Specialty Care Dentist. Specialty Care Dentists have agreed, in return for compensation to be paid in accordance with a fee schedule Allowance, to provide Members with Specialty Dental Services which are authorized and approved by Horizon professional personnel.

E. HOW TO ENROLL

You may enroll for dental benefits by completing an enrollment form for Yourself and each of Your Dependents and delivering it to the Group, who will then submit the enrollment form to

Horizon. If You enroll Your Dependents when You first become eligible, their coverage will become effective on the same date as Yours. For coverage to be effective on the date You first become eligible (after the completion of any applicable Waiting Period), Horizon must receive the enrollment form on or before the 31st day after the date You first become eligible for coverage.

If Horizon does not receive Your enrollment form within the time frame described above, You and each of Your Dependents is a Late Enrollee.

You may apply for enrollment at any time after the above period, subject to Our Underwriting Requirements. In that case, coverage will become effective on the first (1st) day of the calendar month after Horizon receives the completed enrollment form. You may apply for enrollment during the next Open Enrollment Month. Coverage will become effective on the first (1st) day of the calendar month after the last day of the Open Enrollment Month.

If Horizon received a completed enrollment form from You on or after the Effective Date and You are not Active at work, as Determined by Horizon, coverage for You and Your eligible Dependents will not be effective until the first (1st) day of the calendar month after You return to Active work.

However, if You initially waived coverage under the Policy stating that such waiver was due to coverage under another group plan, Horizon will not consider You and/or Your Dependent to be a Late Enrollee, provided the coverage under the other plan ends immediately prior to Your seeking to enroll due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Your Spouse; or

d. termination of the other plan's coverage.

Horizon must receive Your application within 60 days of termination of the coverage provided under the other group's dental benefits plan.

Horizon will not consider Your Spouse or eligible Child Dependents for which You initially waived coverage to be a Late Enrollee, if You are under legal obligation to provide coverage due to a court order. If Your Spouse or eligible Child Dependents are enrolled within 31 days of the issuance of the court order, coverage will take effect as of the date pursuant to the court order.

If Your Spouse or Child Dependent is not enrolled within 31 days pursuant to a court order, then coverage will take effect the first (1st) day of the calendar month following the enrollment of the Spouse or Child Dependent.

LATE ENROLLEES.

If You are a Late Enrollee, You may apply for enrollment for Yourself and each of Your Dependents only during re-enrollment months. Coverage will become effective on the first (1^{st}) day of the calendar month after Horizon receives and approves the completed enrollment form
The re-enrollment month must occur at least 12 months after the Dependent was last eligible for coverage. Re-enrollment opportunities will continue for the Dependent after each twelve (12) month interval.

An eligible Dependent who is a Late Enrollee may have You apply for enrollment for the Dependent only during the next re-enrollment months. Coverage will become effective on the first (1^{st}) day of the calendar month after Horizon receives and approves the completed enrollment form. The re-enrollment month must occur at least 12 months after the Dependent was last eligible for coverage. Re-enrollment opportunities will continue for the Dependent after each twelve (12) month interval.

F. WHEN COVERAGE ENDS

Your coverage will end on the first of the following dates:

a. the end of the calendar month in which You cease to be an Active Full-Time Employee for any reason. Such reasons include disability, death, Retirement, lay-off, leave of absence (except for an authorized Leave of Absence) and the end of employment.

b. the end of the calendar month in which You stop being an eligible Employee under the Policy.

c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.

d. the last day of the period for which required payments are made.

e. if any premium is not paid by the Employer by the end of its Grace period, the date that period ends. If the Employer requests that the Policy be ended at the end of the period for which premiums have been paid, or at anytime during the grace period, coverage will end on the date so requested.

Also, You may have the right to continue certain group coverage for a limited time after Your coverage would otherwise end. The Continuation Rights section explains these situations.

When Dependent Coverage Ends

A Dependent's Coverage will end on the first of the following days:

a. the end of the calendar month in which the Dependent no longer meets the eligibility requirements or the definition of Dependent under the Policy.
b. the date on which coverage for You ends.
c. the date on which the Policy ends.
d. the date Dependent coverage is terminated from the Policy for all Subscribers or for an Employee's class.
e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the month for which You made the required payments, unless coverage ends earlier for other reasons.
f. the end of the calendar month in which a Child Dependent other than a full-time student attains the maximum age for a Child Dependent.
g. the date/end of the calendar month in which a Child Dependent who is a full-time student attains the maximum age for a full-time student Child Dependent or, if earlier, ceases to be a full-time student.
h. if termination is for any other reason, coverage ends at the end of the calendar month in which the Dependent is no longer eligible.

Coverage for a Domestic Partner will end on the last day of the Calendar Month in which the Domestic Partnership ends.

We will terminate Your coverage immediately if You or any of Your Dependents have engaged in fraud or intentionally made any false statement in Your enrollment form or in any claim for benefits under Your coverage.

G. TYPES OF ENROLLMENT COVERAGE

You may enroll under one of the following types of coverage:

1. Employee Coverage. Coverage under the Policy for an Employee only.
2. Employee +1 Coverage. Coverage under the Policy for an Employee and one Dependent.
3. Employee + 2 or more Coverage. Coverage under the Policy for an Employee and two or more Dependents.

H. CHANGE IN TYPE OF COVERAGE

If You gain or lose a member of Your family or whenever someone covered under the Policy changes eligibility status, You should check to see if Your type of coverage should be changed. This can happen for many reasons, for example, through the birth or adoption of a Child or the divorce or death of a Spouse.

If You want to change Your type of coverage, see Your benefits representative . If You have Employee coverage, You must submit an enrollment form to change to any other type of coverage. If You marry, You should apply for a change in coverage within thirty-one (3l) days of such event. Coverage will begin on the first (1st) day of the calendar month following the date of legal marriage. If Horizon does not receive the enrollment form within the 31 days, your change in coverage begins on the first (1st) day of the calendar month commencing after the date on which Horizon receives the enrollment form.

I. CONTINUATION RIGHTS

When You Leave the Group Due To Total Disability:

If You become ineligible for coverage under the Policy due to Total Disability, You can arrange to continue the Policy's coverage if You:

- were continuously enrolled under the Policy for the three months immediately prior to the date Your employment or eligibility ended;

- notify the Employer in writing that You want to continue coverage (within 31 days of the date the coverage would otherwise end);

- make any required contribution toward the group rate for the continued coverage.

The continued coverage under the Policy for You and covered Dependents, if any, will end at the first of these to occur:

- Failure to make timely payment of any contribution required by the Employer. If this happens, coverage stops at the end of the period for which contributions were made.

- The date You become employed and eligible for benefits under another group health plan ; or, in the case of a Dependent, the date the Dependent becomes employed and eligible for such benefits.

- The date the Policy ends for the class of which You were a member.

- In the case of a Dependent, the date that he/she ceases to be an eligible Dependent.

Coverage under the Policy is also available to You (and any eligible Dependents), subject to the above requirements, if You are a Totally Disabled former Employee whose group health coverage (for You and those Dependents) under the Employer's plan provided by another carrier was continued without interruption pursuant to state law.

Continued Coverage Under The Federal Family And Medical Leave Act:

This Section may not apply to Your Policy. You must contact Your Group to find out if the Group must allow for a Family or Medical Leave of Absence under Federal law in which case, this section applies to You.

If You take a leave that qualifies under the Federal Family and Medical Leave Act (FMLA) (e. g., to care for a sick family member, or after the birth or adoption of a Child Dependent), You may continue coverage under the Policy. Coverage may also be continued for Your Dependents.

You will be subject to the same Policy rules as an Active Employee. But, your legal right to have your Employer pay its share of the required premium, as it does for Active Employees, is subject to your eventual return to Active work.

Coverage that continues under this law ends at the first to occur of the following:

- The date You again become Active.
- The end of a total leave period of twelve (12) weeks in any twelve (12) month period.
- The date coverage for You or a Dependent would have ended had he/she not been on leave.
- Your failure to make any required contribution.

Continued Coverage For Surviving Dependents

Covered Dependents of a deceased Employee may have coverage continued under this Program until the first to occur of the following:

- The date which is one hundred eighty (180 days) after Your death.
- The date the Dependent fails to make any required contribution for the continued coverage.
- The date on which the Dependent is no longer an eligible Dependent.
- The date the Policy's coverage for Your class ends.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), You and Your enrolled Dependents, and any newborn or newly adopted child may have the opportunity to continue group dental coverage that would otherwise end, if any of these events occur:

- Your death;
- Your work hours are reduced;
- Your employment ends for a reason other than gross misconduct.

Each of Your enrolled Dependents has the right to continue coverage if it would otherwise end due to any of these events:

- Your death;
- Your work hours are reduced;
- Your employment ends for reason other than gross misconduct;
- He/she became entitled to Medicare benefits;
- In the case of Your Spouse, the Spouse ceased to be eligible due to divorce or legal separation; or
- In the case of a Child Dependent, he/she ceased to be a Child Dependent under this Policy's rules.

You or Your Dependent must notify the benefits representative of a divorce or legal separation, or when a child no longer qualifies as a Child Dependent. This notice must be given within sixty (60) days of the date the event occurred. If notice is not given within this time, the Dependent will not be allowed to continue coverage.

You will receive a written election notice of the right to continue the insurance. In general, this notice must be returned within sixty (60) days of the later of: (a) the date the coverage would otherwise have ended; or (b) the date of the notice. The person asking for coverage must pay the required amount to maintain it. The first payment must be made by the forty-fifth (45^{th}) day after the date the election notice is completed.

If You and/or Your Dependents elect to continue coverage, it will be identical to the dental coverage for other members of Your class. It will continue as follows:

- Up to eighteen (18) months in the event of the end of employment or a reduction in hours. Further, if You or a covered Dependent is/are determined to be disabled, according to the Social Security Act, at the time he/she became eligible for COBRA coverage, or during the first sixty (60) days of the continued coverage, that person and any other person then entitled to the continued coverage may elect to extend this eighteen (18)-month period for up to an extra eleven (11) months. To elect this extra eleven (11) months, the person must give the Employer written proof of Social Security's determination before the first to occur of: (a) the end of the eighteen (18)- month continuation period; or (b) sixty (60) days after the date the person is determined to be disabled.
- Up to thirty-six (36) months for your Dependent(s) in the event of: Your death; divorce or legal separation; entitlement to Medicare; or Your child ceasing to qualify as a Child Dependent.

Continuation coverage for a person will cease before the end of a maximum period just described if one of these events occurs:

- This Program ends for the class You belong to.
- The person fails to make required payments for the coverage.

- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which pre-existing conditions are excluded, or benefits for them are limited, under the other plan.
- The person becomes entitled to Medicare benefits.

If: a person's COBRA coverage was extended past eighteen (18) months due to total disability; and there is a final determination (under the Social Security Act) that the person, before the end of the additional continuation period of eleven (11) months, is no longer disabled, the coverage will end on the first of the month that starts more than thirty (30) days after that determination.

If: (a) this Program provides coverage for Retirees and their eligible Dependents; and (b) their Employer has entered into a bankruptcy proceeding under Title XI, United States Code, COBRA contains provisions for continued coverage for Retirees and Dependents who may be affected by the bankruptcy. If you think that these provisions may apply to You, see Your benefits representative for details.

The above is a general description of COBRA's requirements. If coverage for You or a Dependent ends for any reason, he/she should immediately contact the benefits representative to find out if coverage can be continued. The Employer is responsible for providing all notices required under COBRA.

Coordination Among Continuation Rights Provisions

If You elect to continue Your group health benefits under both this Program's COBRA provisions and any other continuation provision of this Program, the continuations:

a. start at the same time;

b. run concurrently; and

c. end independently on their own terms.

While covered under more than one continuation provision, You:

a. will not be entitled to duplicate benefits; and

b. will not be subject to the Premium requirements of more than one provision at the same time.

Extension Of Coverage Due To Termination of the Group Policy

This applies if You or an eligible Dependent are Totally Disabled on the date coverage ends due to termination of the Policy. In this event, benefits will continue to be available for that

person for Covered Services needed due to the illness or injury that caused the disability. Benefits will continue to be paid during the uninterrupted period of the disability, but not for more than ninety (90) days from the date the coverage ends.

J. EXTENSION OF COVERAGE

Coverage will be extended for services provided within thirty (30) days after a person's coverage ends, but only for the following Covered Services:

1. an appliance, or alteration of one for which a final impression was made while the person was a Member.
2. a crown, bridge, inlay or onlay for which the tooth was prepared while the person was a Member.
3. root canal therapy for which the pulp chamber was opened while the person was a Member.

During a period of coverage extension, Coverage for these Covered Services (and only for these Covered services) will be provided as if the person was still a Member.

K. CONTINUED COVERAGE PURSUANT TO MICHELLE'S LAW

This provision applies to a Child Dependent who was a Covered Person under the Policy on the basis of being a student at a postsecondary educational institution (e.g., a college, university or vocational school) immediately before the first day of a Medically Necessary Leave of Absence.

For the purpose of this provision, a Medically Necessary Leave of Absence is a leave of absence from the postsecondary educational institution, or any other change in the Child Dependent's enrollment in the institution, that:

(a) starts while the Child Dependent is suffering from a serious illness or injury;

(b) is medically necessary; and

(c) causes the Child Dependent to lose student status for the purposes of the coverage under the Policy.

Pursuant to the federal "Michelle's Law" and regardless of anything in the Policy to the contrary, if the Child Dependent's physician certifies in writing to Horizon that: (i) the Child Dependent is suffering from a serious illness or injury; and (ii) the leave of absence or other change in enrollment is medically necessary, then the Child Dependent's coverage under the Policy shall not end until the first to occur of the following:

(1) the date on which the Child Dependent's coverage under the Policy would otherwise end, e.g., due to the termination of the Policy, or due to the Child Dependent's attainment of a maximum age limit;

(2) the Medically Necessary Leave of Absence ends without a return of the Child Dependent to a student status that meets the Policy's rules;

(3) the date that is one year after the first day of the Medically Necessary Leave of Absence.

DEFINITIONS

This section defines certain important words used in this Evidence of Coverage. The meaning of each defined word (when the first letter is capitalized) is governed by its definition in this section.

ACCIDENTAL INJURY / ACCIDENT. A sudden or unforeseen result of a non-chewing event, occurrence, or trauma which causes injury to the mouth and is definite as to time and place.

ACTIVE. Performing, doing, participating, or similarly functioning in a manner usual for the Group task for full pay, at the Group's place of business, or at any other place that the Group's business requires You to go. If You are on an authorized Family or Medical Leave of Absence, You shall be considered Active for the purpose of Determining eligibility for coverage.

AFFIDAVIT OF DOMESTIC PARTNERSHIP. A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership to the Group and Horizon is required prior to Domestic Partner coverage becoming effective. In order to be a valid Affidavit of Domestic Partnership for purposes of this Policy, the definition of Domestic Partners contained therein must be identical to the definition contained in the definition of Domestic Partner under the Policy (see below).

ALLOWANCE. An amount which Horizon negotiates for a Covered Service.

ALTERNATE DENTAL PLAN. The dental plan the Group designates as an alternate to the coverage under the Policy/A dental benefit plan option offered by the Group in lieu of the Policy.

BASIC DENTAL SERVICES. Services contained in the Schedule of Basic Dental Services, Section.

BENEFIT YEAR. The twelve (12)-month period starting on January 1 and ending on December 31 of each year. A Member's first and last Benefit Year may be less than a full year. The first Benefit Year begins on the Member's coverage effective date as shown on the identification card; the Member's Benefit Year ends when he or she is no longer covered under the Policy. Covered Services must be initiated and rendered during this period in order to be eligible for Payment.

CHILD

1. A Child described below who has not yet attained termination age as determined by the Group Contract, is unmarried, is wholly dependent upon You for support and maintenance, does not have and is not eligible for dental coverage through his or her place of employment, is classified as a dependent under federal tax law and claimed as a dependent on Your federal income tax form return, and is:

    a. a natural born Child or stepchild or foster child of You or Your Spouse who resides in New Jersey regardless of with whom the child resides. However, a natural born Child of You or Your Spouse who is born out of wedlock must reside with You. We may waive this residency requirement if a court decree specifies that You are responsible for the Child's dental care expenses. However, the Child must reside in New Jersey;
    b. a legally adopted Child of You or Your Spouse who resides in New Jersey regardless of with whom the child resides provided proof of adoption, as Determined by Horizon, is submitted to Horizon when requested;
    c. a legal ward or foster child of You or Your Spouse who resides with You in a regular parent-child relationship provided proof of guardianship, as Determined by Horizon, is submitted to Horizon when requested.

2. A Child otherwise defined above but who has attained the termination age as determined by the Policy and who We determine is incapable of self-sustaining employment by reason of mental or physical handicap or developmental disability and who meets these requirements shall be considered a Child if he/she: depends on You or Your Spouse/Domestic Partner for support and maintenance; became so incapable prior to attaining the termination age as determined by the Policy; initially enrolled under the Policy or any other policy before reaching the age limit; and stayed continuously covered after reaching the termination age.

    Note: Proof of the handicap or disability as Determined by Us must be submitted to Us within thirty-one (31) days of the last day of the calendar month in which the Child attained the termination age determined by the Group. Thereafter, proof need only be provided once every two (2) years.

3. A Child otherwise defined above but who has attained the termination age as determined by the Policy and who We determine is a full-time student at an accredited institution of higher learning shall be considered a Child under the Policy until he or she attains a termination age as determined by the Policy.

4. A Child born to Your Child Dependent is not considered a Child under the Policy.

    Proof of support, adoption, handicap, residency, student status and all other matters pertaining to eligibility as a Child Dependent, as determined by Us, must be submitted to Us when requested.

COINSURANCE. A percentage which You must pay either at the time certain Covered Services are rendered or for a certain period of time, as indicated.

COPAYMENT. A specified dollar amount which You must pay either at the time certain Covered Services are rendered or for a certain period of time, as indicated. Your Copayment amounts are indicated in the attached schedule.

COVERED SERVICES. The types of services and supplies described in the Schedule of Covered Services. They must be: (a) Necessary and Appropriate Dental Services; and (b) recommended, arranged or rendered by a Primary Care Dentist, or by a Specialty Care Dentist, if authorized by Us, or by a Dentist authorized by Us. Horizon will provide Payment according to all Policy terms.

DENTIST. An individual licensed by the respective State Board to practice dentistry and acting within the scope of his or her dental licensure.

DEPENDENT. A Spouse or Domestic Partner or Child whom the Subscriber enrolls for coverage. A Dependent is not a person who is: (a) on active duty in any armed forces of any country; or (b) covered under the Policy as a Subscriber. No one may be a Dependent who is eligible under the Policy as an Employee.

DETERMINATION BY HORIZON/DETERMINE/DETERMINED. Horizon's sole right to make a decision. This decision will be applied in a reasonable and non-discriminatory manner. The Member has the right to request a review of Horizon's decisions in accordance with the Case Review Procedures described in the General Provision section.

DOMESTIC PARTNER. Persons of the same sex who meet these criteria:

(1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidence by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:
   a. a joint deed, mortgage agreement or lease;
   b. a joint bank account;
   c. designation of one of the persons as a primary beneficiary in the other's will;
   d. designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
   e. joint ownership of a motor vehicle.

(2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;

(3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;

(4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;

(5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each sixty-two (62) years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
(6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
(7) Both persons are at least eighteen (18) years of age;
(8) Both persons file jointly an Affidavit of Domestic Partnership; and
(9) Neither person has been a partner in a domestic partnership that was terminated less than one hundred eighty (180) days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated.

DOMESTIC PARTNERSHIP. A relationship between the Subscriber and another person of the same sex as the Subscriber that meets the requirements set forth within the Policy. Proof that such a relationship exists, as Determined by Horizon, must be submitted to Horizon when requested. Horizon may determine eligibility for coverage under the Policy.

EMERGENCY SERVICES. Services finished by a Dentist which are needed to relieve pain or to prevent worsening of a dental condition that would be caused by further delay.

EMPLOYEE.

a. An individual who:

1. performs services for the Group which are necessary to its business;

2. receives economic compensation from the Group on a periodic basis, which compensation is:

(a) reasonably related to the fair market value of such services; and

(b) included within the person's income for purposes of federal and state income taxes; and

3. performs services under the direction and control of the Group.

(a) Individuals who work on a temporary or substitute or seasonal basis are not considered to be Employees for the purpose of this Policy.

(b) This definition does not include any person who:

1. is an independent contractor or is employed by an independent contractor hired by the Group;

2. receives compensation from the Group but does not perform services which are necessary for the Group's business;

3. is associated with the Group primarily as a student, (other than a student nurse attending a hospital-based school of nursing) even if such person performs services for the Group and receives compensation from the Group;

4. performs services for the Group primarily as a volunteer;

5. is otherwise specifically designated by the Group.

EMPLOYER. Meridian Health.

EXPERIMENTAL OR INVESTIGATIONAL. Dental services or supplies which We Determine are:

1. not of proven benefit for the particular diagnosis or treatment of the patient's particular dental condition; or

2. not generally recognized by the dental community as effective or appropriate for the particular diagnosis or treatment of the patient's dental condition.

3. Notwithstanding the above, We may impose additional criteria to determine whether an Experimental or Investigational service has been provided.

The Policy will not cover any technology if such technology is obsolete or ineffective and is not used generally by the dental community for the particular diagnosis or treatment of a patient's particular dental condition.

FAMILY OR MEDICAL LEAVE OF ABSENCE. A period of time of predetermined length, approved by the Employer, during which you do not work, but after which you are expected to return to Active service. If you have been granted an approved Leave of Absence in accordance with the Family and Medical Leave Act of 1993, you shall be deemed to be Active for purposes of eligibility for services under this Policy.

FULL-TIME. Regularly employed by the Group for and scheduled/budgeted to work an average of thirty-six (36) or more hours per week.

GROUP. The Employer to whom Horizon has issued the Policy [and who is responsible for paying the premiums due.

HORIZON NETWORK. All Primary Care Dentists and Specialty Care Dentists who have agreed to provide or coordinate Covered Services to Members.

INDIVIDUAL. A person who may be or is eligible for coverage under the Policy.

IN-NETWORK DENTIST. A Dentist who has an agreement with Us to furnish Covered Services to Members.

IN-NETWORK SERVICES. Dental services provided or coordinated by an In-Network Dentist.

LATE ENROLLEE. A person who requests enrollment under this Policy more than thirty-one (31) days after first becoming eligible. However, a person will not be considered a Late Enrollee under certain circumstances. See the "How to Enroll" Section of this Policy.

MEMBER. Any enrolled Employee and his or her enrolled Dependent(s).

NECESSARY AND APPROPRIATE DENTAL SERVICES. Services or supplies provided by a Dentist that are Determined by our professional staff to be:

1. appropriate for the symptoms and diagnosis or treatment of a dental condition, illness, disease, or injury;
2. provided for the diagnosis or the direct care and treatment of a dental condition, illness, disease or injury;
3. in accordance with the accepted dental practices in the community at the time; and
4. the least expensive appropriate supply or level of service, as Determined by Horizon, that can be provided under the circumstances.

Notwithstanding the above, We may impose additional criteria to determine whether a Necessary and Appropriate Dental Service has been provided.

We will determine whether a particular dental service is a Necessary and Appropriate Dental Service only for the purpose of determining whether such services are Covered Services not for the purpose of practicing dentistry or determining a course of treatment, which course is to be determined solely by the Primary Care or Specialty Care Dentist.

OPEN ENROLLMENT. Enrollment during a period of at least thirty-one (31) days each year, set by the Group, when You may:

a. while eligible, obtain coverage under the Policy to the same extent as when first eligible after the satisfaction of any required Waiting Periods; or

b. elect to change coverage under this Policy to coverage under an Alternate Dental Plan, to change from coverage under an Alternate Dental Plan to coverage under the Policy.

OUT-OF-NETWORK DENTIST. A Dentist who does not have an agreement with Us to

furnish or coordinate Covered Services to Members.

OUT OF NETWORK SERVICES. Dental services provided by an Out-of-Network Dentist.

PAYMENT. The amount a Primary Care or Specialty Care Dentist, or any other Dentist, will be paid for Covered Services.

PART-TIME. Regularly employed by the Employer and scheduled/budgeted to work an average of fewer than twenty-five (20) hours per week, but no less than thirty-six (36) hours.

POLICY (OR PROGRAM). The Group application, the applicationenrollment forms, the insurance policy and all amendments to it.

PREMIUM. The amount the Group must pay to Horizon.

PREMIUM DUE DATE. The date on which the Premium for the Policy must be paid by the Group.

PRIMARY CARE DENTIST. A Dentist who has agreed with Us to provide Covered Services to Members, or a substitute Dentist arranged for, or recommended, by a Primary Care Dentist and approved by Horizon.

SPECIALTY CARE DENTIST. A Dentist who holds a specialty license in one or more approved dental specialties and has agreed with Us to provide covered specialty dental services to Members.

SPOUSE. The person to whom You are legally married. Proof of legal marriage must be submitted to Horizon when requested.

SUBSCRIBER. An Employee who is enrolled in the Policy.

TOTALLY DISABLED (OR TOTAL DISABILITY), Except as otherwise specified in the Policy, a condition wherein You, due to illness or injury, cannot perform any duty of any occupation for which you are, or may be, suited by education, training and experience, and are not, in fact, engaged in any occupation for wage or profit. [A Dependent is Totally Disabled if he/she cannot engage in the normal activities of a person in good health and or like age and sex.] The person who is Totally Disabled must be under the regular care of a health care practitioner.

UNDERWRITING REQUIREMENTS. The requirements Horizon determines to be appropriate for making, maintaining and administering this policy and coverage for Members.

WAITING PERIOD. A period during which an Employee is not Eligible for coverage.

WE, US, OUR. Horizon Healthcare Dental, Inc.

YOU, YOUR, YOURS. An Employee who is eligible for enrollment through the Group.

COVERED SERVICES

A. PAYMENT FOR COVERED SERVICES

Non-Emergency Services. Payment for Covered Services are made directly to the Primary Care Dentist and the Specialty Care Dentist as mutually agreed. Payment by Us does not include any Copayment or Coinsurance, as applicable. Any Copayments or Coinsurance are shown in the attached schedule.

Emergency Services. Coverage for Emergency Services is provided at the lesser of 50% of the Dentist's charge or 50% of Our Allowance, up to a maximum of $100.00 per emergency if Emergency Services are rendered by other than a person's Primary Care Dentist. Benefits for Emergency Services may be paid either directly to the Dentist, or to You, as determined by Horizon.

BASIC SERVICES PROVIDED BY Primary Care DENTISTS

Coinsurance is payable by the Member for some Basic Services as listed in the Schedule of Services. The amount of Coinsurance is a percent of the Primary Care Dentist's usual fee for that service, as reported to Horizon. "Usual fee" means the fee the Primary Care Dentist charges to patients in general. The Primary Care Dentist will furnish his/her usual fee for a particular procedure upon request. It is not part of the Policy and may be changed from time to time. It is only used for the purpose of calculating Coinsurance and is not the basis for compensation to the Primary Care Dentist. Horizon compensates Primary Care Dentists based on separate, negotiated agreements. These agreements may vary among Primary Care Dentists.

The Coinsurance percent that applies is shown in the Schedule of Covered Services.

SPECIALTY DENTAL SERVICES PROVIDED BY SPECIALTY CARE DENTISTS

Coinsurance is payable by the Member for some Specialty Dental Services as listed in the Schedule of Covered Services.

The amount of Coinsurance is a percent of the Specialty Care Dentist's fee for that service. The "fee" is a fee agreed to by the Specialty Care Dentist. It is not part of the Policy and may be changed from time to time. It is used only for the purpose of calculating Coinsurance and is not the basis for compensation to the Specialty Care Dentist. Specialty Care Dentists are compensated based on separate, negotiated agreements. These agreements may vary among Specialty Care Dentists.

In each instance, the Member will be informed of the fee when visiting a Specialty Care Dentist.

The Coinsurance percent that applies is shown in the Schedule of Covered Services.

B. DENTAL CARE MANAGEMENT

When there is more than one acceptable treatment available to a Member, coverage will be provided for the least costly of the procedures. However, if:

1. a service which is not in the Schedule of Services is furnished for the dental care of a specific condition, and

2. the Schedule includes one or more services which, under standard practices, are separately suitable for the dental care of that condition,

then, in that case, the service in the schedule which will be considered is that service, as Determined by Horizon, which would have produced an acceptable result.

If a more costly procedure is requested by the Member, the Member would then be responsible for the Copayment or Coinsurance, if any, for the least costly procedure and the cost difference between the requested procedure and the least costly procedure. This cost difference must be paid by the Member directly to the Dentist.

C. SCHEDULE OF COVERED SERVICES

Some services are limited. See the Exclusions and Limitation sections for these limitations.

SCHEDULE OF BASIC DENTAL SERVICES

PLAN E Schedule Pages

BASIC SERVICES - PART A

a. PREVENTIVE & DIAGNOSTICS

- Office visit for observation – no other services performed — No Charge
  - Oral examinations — No Charge
- Emergency palliative treatment — No Charge
- Prophylaxis, treatment to include scaling and polishing — No Charge
  - Topical application of fluoride — No Charge
- Study models — No Charge
- Oral hygiene instruction — No Charge
- Sealants — No Charge

b. X-RAYS

- Bitewing X-rays — No Charge
- Entire mouth series/Panoramic — No Charge
- Periapical X-rays — No Charge
- Intra-oral, occlusal view, maxillary or mandibular — No Charge
- Extra-oral, maxillary or mandibular — No Charge

c. ENDODONTICS - Includes local anesthetics and post-operative care where necessary.

- Pulp vitality test — No Charge
- Pulp capping — No Charge
- Pulpotomy — No Charge
- Apexification — No Charge
- Root canal therapy, including necessary X-rays, final restoration, tooth isolation and cultures but excluding molar cases
  - Anterior — No Charge
  - Bicuspid — No Charge

d. RESTORATIONS AND REPAIRS - Includes local anesthetics where necessary.

- Amalgam restorations
  - 1 surface — No Charge
  - 2 surfaces — No Charge
  - 3 or more surfaces — No Charge
- Composite resin restorations (anterior teeth only)
  - 1 surface — No Charge

2 surfaces	No Charge
3 or more surfaces	No Charge
• Retention pins	No Charge
• Stainless steel crowns	$30 Copayment
• Resin temporary crowns	No Charge
• Recementing inlays, crowns, bridges, space maintainers	No Charge
• Tissue conditioning for dentures	No Charge

e. PERIODONTICS - Includes local anesthetics and post-operative care where necessary.

• Emergency treatment (abscess, acute periodontitis, etc.)	No Charge
• Subgingival curettage	No Charge
• Scaling and root planning	No Charge

f. ORAL SURGERY - Includes local anesthetics and post-operative care where necessary.

• Extractions, uncomplicated	No Charge
• Surgical removal of erupted tooth	No Charge
• Surgical removal of impacted tooth (soft tissue)	No Charge
• Excision of hyperplastic tissue	No Charge
• Excision of pericoronal gingiva	No Charge
• Incision and drainage of abscess (intra & extraoral)	No Charge
• Crown exposure to aid eruption	No Charge
• Removal of foreign body from soft tissue	No Charge
• Suture of soft tissue injury	No Charge

BASIC SERVICES - PART B

g. RESTORATIONS - Includes local anesthetics where necessary.

• Porcelain/metallic/ceramic/composite resin inlays	
1 surface	Not Covered
2 surfaces	Not Covered
• Porcelain/metallic/ceramic/composite resin onlays	
1 surface	No Charge
2 surfaces	No Charge
• Crowns (including build-ups when necessary)	
Acrylic	$50
Copayment	
Acrylic with metal	$145 Copayment
Porcelain	$130 Copayment
Porcelain with metal	$150 Copayment
Full metal crown	$150 Copayment
Gold onlay or 3/4 crown	$140 Copayment
Stainless steel (primary)	$30 Copayment

Stainless steel (permanent)	$30 Copayment
Artificial tooth replacement	
Tru-pontic type	$150 Copayment
Porcelain to metal	$150 Copayment
Plastic processed to gold	$140 Copayment

- Dentures

Complete upper denture	$160 Copayment
Complete lower denture	$170 Copayment
Partial upper/lower (each)	$165 Copayment

• Denture and partial adjustment	No Charge
• Denture and partial repairs	$20 Copayment
• Adding teeth to existing partial or denture	$30 Copayment
• Office reline	$35 Copayment
• Laboratory reline	$45 Copayment
• Recementation	
Inlay	No Charge
Crown	No Charge
Bridge	No Charge
• Habit appliances (bruxism, etc.)	No Charge

h. SPACE MAINTAINERS - Includes all adjustments within 6 months after insertion

• Fixed unilateral or bilateral	No Charge
• Removable unilateral or bilateral	No Charge
• Removable appliance to correct habits	No Charge
• Fixed or cemented appliance to correct habits	No Charge

i. OTHER PROCEDURES

• Broken appointments (less than 24-hour notice)	$25 Copayment
• Emergency visit after normal visiting hours	$25 Copayment

2. SCHEDULE OF SPECIALTY DENTAL SERVICES

SPECIALTY SERVICES - PART A

a. ENDODONTICS - Includes local anesthetics and post-operative care where necessary.

• Apexification	No Charge
• Apicoectomy (per tooth) - first root	No Charge
• Apicoectomy (per tooth) - each additional root	No Charge
• Retrograde Filling	No Charge

•	Root Amputation	No Charge
•	Hemisection	No Charge

b. ORAL SURGERY - Includes local anesthetics and post-operative care where necessary.

•	Removal of residual root	No Charge
•	Removal of odontogenic cyst	No Charge
•	Closure of oral fistula	No Charge
•	Removal of foreign body from bone	No Charge
•	Sequestrectomy	No Charge
•	Frenectomy	No Charge
•	Transplantation of tooth or tooth bud	No Charge
•	Alveolectomy /Alveoplasty	No Charge
•	Removal of exostosis	No Charge
•	Sialolithotomy; removal of salivary calculus	No Charge
•	Closure of salivary fistula	No Charge

c. PERIODONTICS - Includes local anesthetics and post-operative care where necessary.

•	Gingivectomy or Gingivoplasty - per quadrant	No Charge
•	Gingivectomy or Gingivoplasty - per tooth	No Charge
•	Gingival flap procedure - per quadrant	No Charge
•	Pedicle soft tissue graft	No Charge
•	Free soft tissue graft	No Charge
•	Subepithelial connective tissue graft	No Charge
•	Occlusal adjustment (other than with an appliance or by restoration)	
	Limited	No Charge
	Entire mouth	No Charge

SPECIALTY SERVICES - PART B

d. ENDODONTICS - Includes local anesthetics and post-operative care where necessary.

•	Molar Root Canal Therapy, including X-rays and cultures but excluding final restoration	No Charge

e. INTRAVENOUS SEDATION AND GENERAL ANESTHESIA — No Charge

General Anesthesia is only a Covered Service when provided as a Necessary And Appropriate Dental Service, as Determined by Horizon, in conjunction with Covered Oral Surgery Services.

f. ORAL SURGERY - Includes local anesthetics and post-operative care where necessary.

• Surgical removal of impacted tooth,	
Partially bony	No Charge
Completely bony	No Charge

g. PERIODONTICS .

• Osseous surgery, gingivectomy, soft tissue grafts, and post-operative care (including flap entry and closure)	No Charge
• Crown lengthening (hard tissue)	No Charge
• Bone replacement grafts	No Charge
• Guided Tissue Regeneration (GTR), including related procedures	No Charge
• Chemotherapeutic Agents (per site)	No Charge

h. ORTHODONTIC PROCEDURES

• Orthodontic appliances and treatment - Adult and Child Only	$1,000 Copayment

DENTAL SERVICES EXCLUSIONS AND LIMITATIONS

The following are not Covered Services. These exclusions and limitations are in addition to any general exclusions that apply.

1. A service, procedure or supply which:
   a. is not a Necessary And Appropriate Dental Service;
   b. does not have uniform professional endorsement;
   c. is Experimental or Investigational in nature; or
   d. does not have a favorable prognosis.

   While Horizon may make the determination of dental necessity, such administration, interpretation and application may be modified or revised by a Court or regulatory agency with appropriate jurisdiction.

2. A non-Emergency Service furnished by a Dentist who is not a Primary Care Dentist or Specialty Care Dentist.

3. A replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or adding teeth to any of these, or a replacement or modification of a crown, inlay or onlay, within 5 years after that denture, bridge, bridgework, crown, inlay or onlay was installed [unless necessary due to natural tooth loss where the replacement of teeth

to the existing partial is not feasible.

4. Any of the following:
   a. an appliance, or modification of one, if an impression for it was made before the person became a Member;

   b. a crown, bridge, inlay or onlay, if a tooth was prepared for it before the person became a Member;

   c. root canal therapy, if the pulp chamber for it was opened before the person became a Member;

   d. an inlay, onlay, or crown, unless (i) it is treatment for decay or made necessary by an accidental non-chewing injury and teeth cannot be restored with a filling material; or (ii) it is a primary abutment to a covered bridge.

5. A service or supply furnished for cosmetic purposes. Any porcelain components, including full or partial? facings on crowns or pontics, and composite resin fillings, that are posterior to the second bicuspid will always be considered cosmetic.

6. A service or supply in connection with:
   a. an orthodontic service or procedure;

   b. the replacement of lost, broken or stolen appliances;

   c. appliances or restoration needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or restoring tooth structure lost as a result of attrition or abrasion or erosion;

   d. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction or disease of the temporomandibular joint or craniomandibular disorders or its associated structures.

7. A service or supply in connection with or for myofunctional therapy infection control; separate charges for acid etch, treatment of jaw fractures, orthognathic surgery, chemotherapeutic agents, personal supplies, completion of forms, exams by a third party, or professional advice given on the phone.

8. Implants, insertion of implants or related appliances or the surgical removal of implants.

9. Overdentures and associated procedures, specialized techniques, precision or semi-precision attachments.

10. Osseous (bone) grafts.

11. A service not contained in the Schedule of Covered Services.

12. Any hospital costs associated with or in connection with oral surgeries or hospital charges of any other kind.

13. Any general anesthesia.

14. Any of the following services:
   a. Analgesics (such as nitrous oxide) or other euphoric drugs;.
   b. Procedures primarily for the purpose of plaque control (except prophylaxis)or oral hygiene, or dietary instructions;
   c. Major surgery of fractures and dislocations;
   d. Any dental procedure started after termination of eligibility for coverage under the Horizon Program;
   e. The treatment of malignancies;
   f. Any dental procedure unable to be performed in the dental office because of the general health and physical limits of the patient;

g. Full mouth rehabilitation;
h. Services provided to unmanageable children, who, because of their behavior, require the use of a dentist other than their Primary Care Dentist.

15. Services that are usually provided without charge or for which no charge would be made if no dental benefits coverage existed.

GENERAL EXCLUSIONS

This Section tells you when and where coverage will not be provided. These exclusions are in addition to the Dental Limitations and Exclusions.

The following are not Covered Services:

A. Except in the case of Emergency Services, dental services or supplies which were not prescribed, arranged, coordinated, rendered or approved by the Primary Care Dentist.

B. Non-Emergency Services provided by an Out-of-Network Dentist, unless specifically approved or authorized by Horizon.

C. Services which are eligible for payment under either federal or state programs (except Medicare). This provision applies whether or not the Member asserts his/her rights to obtain coverage under the program or payment for these services.

D. Dental services provided by or in a government hospital, or provided by or in a facility run by the Department of Defense or Veteran's Administration for a service-related illness or injury, unless coverage for the services is otherwise required by law

E. Dental services due to an illness or injury, including a condition which is the result of an illness or injury, which (a) occurred on the job; and (b) is covered or could have been covered for benefits provided under a workers' compensation, employer's liability, occupational disease or similar law. However, this exclusion does not apply to the following persons for whom coverage under workers' compensation is optional, unless such persons are actually covered for workers' compensation; a self-employed person, a partner of a limited liability partnership, members of a limited liability company, or partners of a partnership, who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

F. Prescription and non-prescription drugs and medications.

G. Dental services provided to any person who is in the armed forces of any government other than for duty of thirty (30) days or less, except as otherwise provided for under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA).

H. Services or supplies:

a) Needed due to an injury or illness to which a contributing cause was the Member's commission of, or attempt to commit, a felony; or to which a contributing cause was the Member's engagement in an illegal occupation;
b) Furnished by one of these Members of the Member's family, unless otherwise stated in this Policy: Spouse or Domestic Partner, children, parent, in-law, brother or sister

c) Provided if the Member is billed directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the Dentist and the Member.

I. Any of the following services:

(a) Services provided to treat an injury or illness suffered (i) as a result of War or an Act of War, if the injury or illness occurs while the Member is serving in the military, naval or air forces of any country, combination of countries or international organization; and (ii) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the injury or illness occurs while the Member is serving in such forces and is outside the Home Area.
(b) Services provided to treat an injury or illness suffered (i) as result of War or an Act of War while the Member is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (ii) as a result of the special hazards incident to such service, provided the injury or illness occurs while the Member is serving in such unit; and is outside the Home Area.
(c) Services provided to treat any injury or illness suffered as a result of War or an Act of War while the Member is not in the military, naval or air forces of any country, combination of countries or international organization or in nay civilian non-combatant unit supporting or accompanying such forces, if the injury or illness occurs outside the Home Area.

For purposes of this item, the following definitions apply:

"War" includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

"Home Area" includes the 50 states of the United States of America, the District of Columbia and Canada.

"Act of War" includes any act peculiar to military, naval or air operations in time of War.

GENERAL PROVISIONS

A. RELEASE OF INFORMATION

Each Member agrees, as a condition of coverage, that any Dentist or entity having information relating to an illness or injury for which benefits are claimed under the Policy may furnish to Us, upon our request, any such information (including copies of records).

Any information received by Us shall be kept confidential and, except as reasonably necessary in connection with the administration of the Policy, will not be disclosed without the consent of the Member.

Horizon will meet the requirements of state and federal law, including HIPAA, in maintaining the privacy and security of a Member's health, dental and other personal private information ("private information"). A Member's private information may only be requested, accessed, used and disclosed in accordance with the requirements of this Policy and more fully with the Horizon Notice of Information Privacy Practices.

Private information includes, but is not limited to, the following: a Member's identity, history, diagnosis, treatment, prognosis or other health or dental status, as well as the Member's and his/her Dependents' personal demographic information (i.e., address, telephone number, employment and dependent information) and other such information.

Private information shall be accessed only by Horizon personnel acting within the scope of their assigned responsibilities; and such information shall only be used and disclosed in connection with appropriate company business. Horizon personnel are prohibited from disclosing information to unauthorized persons, except as permitted or required by law.

It is the responsibility of all Horizon personnel to be familiar with the provisions of this privacy policy and to maintain the confidentiality of private information in accordance with this policy.

Use of this information in the aggregate based upon dental records of Members where no individual person is identified will not require consent. We have the right to require authorization from a Member's Dentist before releasing dental information.

B. NOTICE OF CLAIM

We will not be liable under the Policy unless You or Your Primary Care Dentist or Your Specialty Care Dentist provide proper notice that Covered Services have been provided.

Written notice must be given not later than one (1) year from the date Covered Services were performed for You[or Your Dependent] who was a Member at the time Covered Services were provided. The notice must include information necessary for Us to determine benefits. An expense will be considered incurred on the date the service or supply was rendered, or in the case of a dental procedure requiring multiple visits, the date the service was completed. Failure to give Us notice within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible.

C. CASE REVIEW PROCEDURE

If a Member disagrees with the disposition of a case or the dental treatment received pursuant to the terms of the Policy, he or she may request a review from Horizon. Either he/she or his/her representative must make the request in writing within one hundred eighty (180) days from receipt of the service and include his or her identification number. Upon receipt of the request for review addressed to Horizon Healthcare Dental, Inc., 3 Penn Plaza East, Newark, New Jersey 07105-2200, Attention: Appeals, the case will be reviewed taking into consideration any related materials which the Member provides. On completion of this review and within fifteen (15) days of Horizon's receipt of the request for review, the Member will be provided with a decision, in writing, explaining the basis for upholding or modifying the original disposition of the case.

Appeals Process

A Member (or a Dentist acting for the Member, with the Member's written consent) may appeal Horizon's administrative or utilization review management (UR) decisions. Administrative decisions involve benefit issues. UR decisions involve a denial, termination or other limitation of dental services. No Member or Dentist who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon.

The appeal process consists of: (a) an informal internal review by Horizon; and (b) a formal internal review by Horizon. Nothing in Horizon's policies, procedures or Dentist contracts prevent a Member (or Dentist acting on behalf of the Member and with the Member's written consent) from discussing or exercising the right to an appeal.

A Member must follow the steps for filing the two levels of appeal. If these steps are not followed, the Member's appeal review may be delayed.

a. First Level Appeal

A Member (or a Dentist acting for the Member, with the Member's written consent) can file a First Level Appeal by calling or writing Horizon at the telephone number and address on the Member's ID card. At the First Level Appeal, a Member may discuss an adverse clinical decision directly with the person who made it, or with the dental director designated by Horizon. All First Level Appeals must be made within one hundred eighty (180) days from the date that Horizon informed the Member of the denial of coverage or payment.

To submit a First Level Appeal, the Member must include the following information:

1) the name(s) and address(es) of the Member(s) or Dentist(s) involved;
2) the Subscriber's ID number;
3) the date(s) of service;
4) the details regarding the actions in question;
5) the nature of and reason behind the appeal;
6) the remedy sought; and
7) the documentation to support the appeal.

We will inform Members of decisions about administrative First Level Appeals within fifteen (15) calendar days after receipt of the required documentation. We will inform Members of decisions about UR First Level Appeals regarding Emergency Service issues within seventy-two (72) hours from receipt of the required documentation, and within five (5) business days of receipt of the required documentation for all other UR issues. Horizon will provide the Member and/or the Dentist with; (a) written notice of the outcome; (b) the reasons for the decision; and (c) instructions for filing a Second Level Appeal.

b. Second Level Appeal

If a Member (or a Dentist acting for the Member, with the Member's written consent) is not satisfied with Horizon's First Level Appeal decision, the Member or Dentist can file a Second Level Appeal before a panel of dental professionals selected by Horizon who were not involved in the original and First Level Appeal decisions. At the Member's request, the Dentist involved in the original clinical decision may take part in the process.

Horizon will acknowledge Second Level Appeals in writing within ten (10) business days of receipt. We will provide written notice of the final decision on the appeal: (a) within seventy-two (72) hours after receipt (in the case of UR appeals that require review on an expedited basis due to an urgent care, Emergency Services or a Necessary and Appropriate Dental Services issue); and (b) within fifteen (15) business days of receipt in the case of all other UR appeals.

Horizon may extend the review for up to an additional fifteen (15) business days when there is a reasonable cause for the delay that is beyond Horizon's control. Horizon will provide the Member or Dentist with written notice of the delay within the original fifteen (15) day period.

If the Second Level Appeal is denied, Horizon will provide the Member and/or Dentist with written notice of the reasons for the denial If You are dissatisfied with this denial, You may write to:

New Jersey Department of Banking and Insurance (DOBI)
Division of Enforcement and Consumer Protection
PO Box 329
Trenton, NJ 08625-0329

D. COORDINATION OF BENEFITS AND SERVICES

A Member may be covered for dental benefits or services by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her Spouse. If he or she is, this provision allows Horizon to coordinate what Horizon pays or provides with what another plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all plans under which the Member is covered.

Definitions

The terms defined below have special meanings when used in this provision. Throughout the rest of this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any dental care service, supply or other item of expense for which the Member is liable when the dental care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When the Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Horizon will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A calendar year, or portion of a calendar year, during which a Member is covered by this Program and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;
d) School accident-type coverage;
e) A State plan under Medicaid.
f) Dental Plans provided by Dental Plan Organizations (DPO).

Primary Plan: A Plan under which benefits for a Member's dental coverage must be determined without taking into consideration the existence of any other Plan.

There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exists:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Member use order of benefit determination rules consistent with those contained in this Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply, based on a standard which is most often charged for a given service by a Dentist within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a Member is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each Secondary plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

Horizon considers each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan(s) will pay the person's remaining unpaid Allowable Expenses that have been incurred during that Claim Determination Period, but no Secondary Plan will pay more in a Claim Determination Period than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Necessary and Appropriate Dental Services on the basis that pre-authorization or pre-approval procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Member as an Employee, Member, Subscriber or Retiree shall be determined before those of the Plan that covers the Member as a Dependent. The coverage as an Employee, Member, Subscriber or Retiree is the Primary Plan.

The benefits of the Plan that covers the Member as an Employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those of the Plan that covers the Member as a laid off or retired Employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Member as an Employee, Member, Subscriber or Retiree, or as the Dependent of such person, shall be determined before those of the Plan that covers the Member under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan covering the parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the Child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.

d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the Employee, Member or Subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

a) The basis on which the Primary Plan and the Secondary Plan pay benefits; and

b) Whether the Dentist who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Dentist bills a charge and the Member may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary Charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Dentist, called an In- Network Dentist, bills a charge, the Member may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Member uses the services of an Out-of-Network Dentist, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the Dentist may be based on a capitation. This means that the carrier pays the Dentist a fixed amount per Member. The Member is liable only for the applicable deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Dentists based upon capitation is called a "Capitation Plan."

In the rules below, "Dentist" refers to the Dentist who provides or arranges the services or supplies.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Dentist is an In-Network Dentist in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Dentist receives from the Primary Plan, the Secondary Plan and the Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the Coinsurance, Copayment and/or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the Dentist is an In-Network Dentist in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, Coinsurance or Copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO or DPO Plan that does not allow for the use of Out-of-Network Dentists except in the event of Emergency Services and the service or supply the Member receives from an Out-of-Network Dentist is not considered as an Emergency, the Secondary Plan shallpay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Member receives services or supplies from a Dentist who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b) The amount the Secondary plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is

Capitation Plan

If the Member receive services or supplies from a Dentist who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Dentist and shall not be liable to pay the deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Member shall not be liable to pay any deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan.

BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

This section applies when expenses are incurred by a Member due to an Automobile Related Injury.

Definitions

"Automobile Related Injury": Bodily injury of a Member due to an accident while occupying, entering into, alighting from or using an auto; or if the Member was a pedestrian, caused by an auto or by an object propelled by or from an auto.

"Allowable Expense": A reasonable and customary item of expense that is at least in part an Eligible Expense under this Program or PIP.

"Eligible Expense": That portion of expense incurred for treatment of an injury, which is covered under this Program without application of deductibles, Coinsurance or Copayments, if any.

"Out-of-State Automobile Insurance Coverage" or "OSAIC": Any coverage for dental expenses under an auto insurance contract other than PIP. This includes auto insurance contracts issued in another state or jurisdiction.

"PIP": Personal injury protection coverage (i.e., medical expense coverage) that is part of an auto insurance contract issued in New Jersey.

Application of this Provision

When expenses are incurred as a result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this provision will be used to determine whether this Program provides coverage that is primary to such coverage or secondary to such coverage. It will also be used to determine the amount payable if this Program provides primary or secondary coverage.

Determination of Primary or Secondary Coverage

This Program provides secondary coverage to PIP unless health coverage has been elected as primary by or for the Member under the Program. This election is made by the named insured under a PIP contract. It applies to that person's family members who are not themselves named insured under other auto contracts. This Program may be primary for one Member, but not for another if the persons have separate auto contracts and have made different selections regarding the primacy of the health coverage.

This Program is secondary to OSAIC. But, this does not apply if the OSAIC contains provisions that make it secondary or excess to the Member's other health benefits. In that case, this Program is primary.

If the above rules do not determine which coverage is primary, or if there is a dispute as to whether this Program is primary or secondary, this Program will provide for Covered Services as if it were primary.

Benefits This Program Will Pay if it is Primary to PIP or OSAIC.

If this Program is primary to PIP or OSAIC, it will pay benefits for Covered Services in accordance with its terms. If there are other plans that: (a) provide benefits to the Member; and (b) are primary to auto insurance coverage, then this Program's rules regarding the coordination of benefits will apply.

Benefits This Program Will Pay if it is Secondary to PIP.

If this Program is secondary to PIP, the actual coverage will be the lesser of:

a. the Allowable Expenses left uncovered after PIP has provided coverage (minus this Program's Copayments and/or Coinsurance);
b. the actual benefits that this Program would have paid if it provided its coverage primary to PIP.

Medicare

To the extent that this Program provides coverage that supplements Medicare's, then this Program can be primary to automobile insurance only insofar as Medicare is primary to auto insurance

E. APPLICABLE LAW

The Policy is administered according to the laws of New Jersey.

F. CONFORMITY WITH LAW

Any provision of the Policy that conflicts with the requirements of an applicable law or regulation of the State of New Jersey or the federal government is automatically changed to conform with the minimum requirements of that law or regulation.

G. COVERED SERVICES TO WHICH MEMBERS ARE ENTITLED

1. The liability of Horizon is limited to the Covered Services specified.

2. No person, other than a Member, is entitled to receive Covered Services. Such right to coverage is not transferable, either before or after Covered Services are rendered.

3. Covered non-Emergency Services specified in the Policy must be provided only by a Primary Care Dentist or Specialty Care Dentist or a Dentist authorized by Horizon.

H. TERMINATION OF A MEMBER'S COVERAGE

Coverage of a Member ends upon the occurrence of any of the following events:

1. The Policy is terminated. Termination of the Policy automatically terminates each Member's coverage. It is the Group's responsibility to notify all Members of their termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

2. The Member has engaged in fraud or intentionally made any false or untrue statement in the enrollment form or in any claim for benefits or services under the Policy.

3. The Member no longer meets the eligibility requirements for the Policy.

CIVIL UNIONS

I. The following terms shall have the meanings set forth below:

Civil Union: A union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a Civil Union.

Civil Union Partner: A person who has established and is in a Civil Union.

II. Pursuant to New Jersey law, the Policy is changed in the following respects:

(a) Except as otherwise provided in (c), below, all of the rights, benefits, obligations and privileges granted under the Policy to an Employee with respect to a Spouse and their Child Dependents shall also apply equally with respect to: (i) an Employee and a person with whom he/she has established a Civil Union; and (ii) the Child Dependents of the Employee and his/her Civil Union Partner.

(b) Except as otherwise provided in (c) below, any provision of the Policy that affects a Spouse upon his/her divorce or legal separation from the Employee shall, subject to the Policy's terms and conditions, also equally affect an Employee's Civil Union Partner upon dissolution of the Civil Union. Such provisions include, but are not limited to, the following:

(i) Termination of the Civil Union Partner's coverage.

(ii) The right of the Civil Union Partner to convert to an individual health policy.

(a) Regardless of anything above to the contrary, any right to continue the Policy's coverage that is granted to an Employee's Spouse pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall not apply with respect to an Employee's Civil Union Partner.

ORTHODONTIC BENEFITS RIDER

This Policy provides the following benefits for orthodontic treatment to those described below as being Eligible Members.

A. ELIGIBLE MEMBERS

This rider provides for partial payment for Orthodontic Procedures performed by a Specialty Care Dentist for a Child Dependents age 19 or less.

Coverage under this rider ends on the date the Child Dependent ceases to be a Member.

B. DEFINITIONS

These terms have the following meanings when used in this rider:

Amounts. The total estimated benefits to be paid to the Specialty Care Dentist in installments over the estimated duration of the Orthodontic Treatment Plan.

Orthodontic Procedure. The use of active appliances to move teeth, to correct:

1. faulty position of teeth (malposition); or
2. abnormal bite (malocclusion).

Orthodontic Treatment Plan. A Specialty Care Dentist's report, on a form approved by Horizon Healthcare Dental, Inc. that:

1. states the class of malocclusion or malposition;
2. recommends and describes needed treatment by Orthodontic Procedures;
3. estimates the duration of the treatment;
4. estimates the total charge for the treatment; and
5. includes cephalometric x-rays, study models and any other supporting evidence that Horizon Healthcare Dental, Inc. may reasonably require.

C. COVERED SERVICES

Covered Services are those provided in connection with the Orthodontic Procedures performed on persons described in Section A of this rider and described in an Orthodontic Treatment Plan.

An orthodontic service is a Covered Service if all of these conditions are met:

1. It is made for a service or supply furnished in connection with an Orthodontic Procedure and before the estimated duration shown in the Orthodontic Treatment Plan expires;
2. An active appliance for that Orthodontic Procedure is inserted while the Member was covered;
3. The Orthodontic Procedure is needed to correct one of these conditions:
   a. vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet),
   b. faulty alignment (either frontwards or backwards) of the upper and lower arches with each other,
   c. cross-bite;
4. The service or supply is made part of an Orthodontic Treatment Plan that, before the Orthodontic Procedure is performed, has been:
   a. sent to Horizon Healthcare Dental, Inc. for review, and
   b. returned by Horizon Healthcare Dental, Inc. to the Dentist showing authorization for the service and amounts of coverage.
5. A treatment plan is no longer twenty-four (24) months. Treatment that extends beyond 24 months from the beginning of active treatment will be subject to an office visit charge per visit after 24 months.
6. It is not listed in "Services Not Covered" below.

The Member is responsible for any Copayment based on the Specialty Care Dentist's schedule of fees that have been negotiated by Horizon. The Copayment will vary based on the plan selected by the Group. The Copayments is shown in the Schedule of Specialty Dental Services.

The Invisalign modality of treatment is a Covered Service under this Policy. Invisalign may require an additional Copayment, which is equal to any cost over and above a non-Invisalign orthodontic treatment.

D. SERVICES NOT COVERED

1. Benefits will be discontinued if the Member ceases to be covered for any reason under the Policy or this rider.

2. Any services for an Orthodontic Procedure if an active appliance for that Orthodontic Procedure has been installed before the first day on which the person becomes covered by this rider.

3. Covered Services will not be provided for more than one complete course of orthodontic treatment in a member's lifetime.

4. If a Member does not require treatment or refuses to complete treatment, he will still be required to pay the orthodontist start-up costs not to exceed $350.00 for the initial examination, diagnosis, consultation, study-model impressions, and the retention phase of treatment.

If a Member abandons orthodontic care or discontinues orthodontic treatment for a period of 6 or more months, any added costs to resume orthodontic treatment will be the responsibility of the Member.

5. The European method of orthodontics, Phase 1 or interceptive orthodontic treatments - activator appliances used in conjunction with eventual banding - is to be considered as part of or full treatment.

6. Lost , broken or stolen appliances.

7. Changes in treatment necessitated by accident of any kind.

8. Myofunctional therapy.

9. Surgical procedures related to cleft palate, micrognathia or macrognathia.

10. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.

11. Dispensing of drugs.

12. General anesthetics including intravenous and inhalation sedation.

13. Dental services of any nature performed in a hospital.

14. Any dental procedure considered within the field of general dentistry such as filings or extractions.

15. Malocclusions which are so severe or mutilated so as not to be amenable to ideal orthodontic therapy.

16. Treatment that extends beyond twenty-four (24) months from the beginning of active treatment will be subject to an office visit charge.

All other benefits and terms of the Policy not changed above remain in force. This change is part of the Policy.

SUMMARY PLAN DESCRIPTION SUPPLEMENT

Horizon Blue Cross Blue Shield of New Jersey Dental Plans of Meridian Health

The certificates entitled "Horizon Gold Plan (Horizon Dental Option)," "Horizon Silver Plan (Horizon Dental Preventive PPO Access)," and "Horizon Bronze Plan (Horizon Dental Choice)" (together, the "Certificates") describe the group dental insurance benefit options that Meridian Health sponsors. The benefit options as set forth in the Certificates make up the insured dental component program (the "Plan") described in this Summary Plan Description Supplement ("Supplement"). The Plan is offered under the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan"), sponsored by Meridian Health.

This Supplement and the Certificates constitute the summary plan description ("SPD") for the Plan. The Supplement is intended to clearly summarize a complex benefits plan, not to alter or modify the Plan. If there are any inconsistencies between the Supplement and the Certificates, the actual terms of the Certificates will control. The SPD may be modified from time to time by a Summary of Material Modifications ("SMM") that will be issued by Meridian Health. Any SMM related to the Plan is considered to be part of this SPD. This SPD describes the Plan coverage in effect on January 1, 2014. Please see the prior SPDs and SMMs for information concerning plan provisions prior to that date. Subsequent SPDs or SMMs will be provided to advise you of changes in Plan, as required by the Employee Retirement Income Security Act (ERISA).

Please read the information in this Supplement and the related Certificates carefully so that you will have a full understanding of your Plan benefits. This Supplement includes summary information relating to:

- Who is eligible to participate in the Plan
- When Meridian Health may amend or terminate the Plan
- What rights you have under several federal laws
- Administrative information about the Plan

The Certificates can be located on the Meridian Health Intranet or at www.TeamMeridian.com. If you would like hard copies of the Certificates, please contact the Meridian HR Support Services Team at 732-751-3553.

Basic Plan Information

Type of Administration	Insurer administration – Benefits are provided and administered under an insurance contract with Horizon Blue Cross Blue Shield of New Jersey ("Horizon")
Plan Name	Horizon Blue Cross Blue Shield of New Jersey Dental Plans of Meridian Health, component plans of the Welfare Benefit Plan of Meridian Health
Plan Number	501
Tax ID Number	22-3471515
Plan Year	January 1 - December 31
Type of Plan	Group Health Plan
Employer Plan Sponsor Information	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753
Participating Employers	See Appendix A
Plan Administrator	Senior Vice President of Human Resources Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753 732-751-3553
Named Fiduciary	Meridian Health 1350 Campus Parkway Neptune, New Jersey 07753 732-751-3553
Agent for Service of Legal Process	Meridian Health Attn: General Counsel 1350 Campus Parkway Neptune, New Jersey 07753

Claims Administrator	Horizon Healthcare Services, Inc. 3 Penn Plaza East Newark, New Jersey 07105-2200
Plan Funding	The Plan is fully insured by Horizon Blue Cross Blue Shield of New Jersey. Premiums are paid by Meridian Health and Plan participants.

Eligibility

Team Members

A person is eligible for team member coverage under the Plan if he or she meets the following requirements:

1. He or she is a full-time, active team member of Meridian Health or any Participating Employer that has adopted the Plan with Meridian Health's approval (an "Employer") (a team member is considered full-time if he or she is scheduled to work at least 36 hours per week and is on the regular payroll of the Employer for that work) or is a part-time, active team member of the Employer (a team member is considered part-time if he or she is regularly scheduled to work at least 20 but less than 36 hours per week and is on the regular payroll of the Employer for that work); and
2. He or she completes the waiting period.

A team member is a person directly employed in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the Employer. Team member does not include an individual designated by Meridian Health to be an independent contractor (whether determined at a later date to be a common law employee or otherwise).

Team members become eligible for coverage on:

1. The effective date of the Plan, if he or she was employed on that date; or
2. The first of the month following his or her first day of employment or, if later, initial eligibility (subject to the conditions listed below)

However, Plan coverage is not automatic. The team member has to timely enroll in the Plan to be covered as an active team member.

Notwithstanding the foregoing, the following team members are not eligible for coverage under the Plan:

- Part-time team members at Meridian Nursing & Rehabilitation Ocean Grove;
- Part-time team members at Wall Subacute;
- Meridian Health Resources physicians who are eligible for dental benefits directly through their practices;
- Part-time team members at Meridian Nursing & Rehabilitation Brick, except for certain grandfathered team members;
- Part-time team members at Meridian Nursing & Rehabilitation Shrewsbury, except for (i) certain grandfathered team members and (ii) team members covered by a collective bargaining agreement providing for coverage;
- Per diem team members; and
- Team members covered by a collective bargaining agreement, unless the terms of the collective bargaining agreement provide for eligibility under the Plan.

Change Events

Your Plan elections will remain in effect until the end of the Plan Year for which they are made, and you will not be able to change your election until the next annual open enrollment period. Outside of the annual open enrollment period, you can only change your Plan elections if you have a "Qualified Change Event." Any election change on account of a Qualified Change Event must be consistent with that event. The Qualified Change Events recognized under the Plan include the following:

Change in Status - You may make a change to your coverage elections when certain change in status events occur, but only if the change is consistent with the event. The coverage change must be on account of and correspond to a change in status event that affects your or your Dependent's eligibility for coverage under the Plan or another employer's plan. The following are change in status events:

- Your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment), you enter into a Civil Union, or you dissolve a Civil Union or Domestic Partnership;
- The number of your eligible Dependents changes (such as when a child becomes your Dependent through birth or adoption; a person's dependent status — as defined by the Internal Revenue Code — changes; or a Dependent dies);
- Your covered Dependent no longer satisfies the requirements for coverage under the Plan because the dependent reaches the limiting age, or any similar circumstance;
- A change in your or your Dependent's employment status, including termination or commencement of employment, change of worksite, or any other change resulting in you or your Dependent becoming eligible or ineligible for benefits under a benefit plan;
- A reduction or increase in your or your Dependent's hours of employment (e.g., due to a change from part-time to full-time status or vice versa, a strike or lockout, or an unpaid leave of absence); or
- A change in your or your Dependent's residence affects eligibility for coverage.

Significant Cost or Coverage Changes – You may also change your coverage elections outside of the annual open enrollment period if:

- Coverage under the Plan is significantly reduced or ends (if the significant reduction results in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, or if no similar option is available, drop coverage; if the significant reduction does not result in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, but you may not drop coverage completely);
- The cost of a benefit option significantly increases (you may elect to pay the increased cost for your current option, select a new benefit option, or revoke your coverage if there is no similar option);
- The cost of a benefit option significantly decreases (you may select that option);
- A similar benefit option is added, significantly improved or eliminated, and you are eligible to elect the new or improved option; or
- There are significant changes under your Spouse's, Civil Union Partner's, or Domestic Partner's plan due to a mid-year election change that satisfies the Internal Revenue Code regulations, or a change during an open enrollment period where your Spouse's, Civil Union Partner's or Domestic Partner's plan has a different plan year or enrollment period than the Plan.

Qualified Medical Child Support Order - Your election under the Plan may be changed as necessary to comply with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requiring you to provide coverage for a dependent child. In addition, if such a judgment, decree, or order requires your former spouse to provide coverage to a dependent child and such coverage is provided, you may elect to terminate coverage for such child.

Upon receipt of an order (from a court or from an administrative agency) requiring enrollment of an eligible dependent child, the team member will be notified if the order constitutes a Qualified Medical Child Support Order (QMCSO) as required under federal law. QMCSO procedures, under which the Plan administers medical child support orders, are available, at no charge, upon request to the Plan Administrator.

Entitlement to Medicare or Medicaid - You may make a corresponding election change under the Plan if you or your Dependent becomes entitled to Medicare or Medicaid coverage, other than coverage relating solely to the distribution of pediatric vaccines, or loses eligibility for such coverage.

How to Change Your Election and/or Participation during the Year

If you have a Qualified Change Event—for example, if you get married—you can make certain mid-year changes to your contribution amounts under the Plan.

You can make coverage changes by completing a Benefit Enrollment/Change Form located on the Meridian Health Intranet or at www.TeamMeridian.com.

If you have a Qualified Change Event during the year and need to change your coverage outside of the annual enrollment period, you must do so within 31 days of the Qualified Change Event. Otherwise, you are not eligible to make a coverage change before the next annual open enrollment period, unless you or your eligible family member has another qualified change in status.

Your new election will be effective as of the first day of the month following the date on which such Plan election is received, provided such election is received by the Plan Administrator (or the representative of the Plan Administrator) within 31 days after the event, except as follows:

- A change election on account of the birth, adoption, or placement of adoption of a new dependent shall be retroactive to the effective date of the event; and
- In the case of an enrollment due to marriage, coverage shall commence on the first day of the month following the date of the marriage.

Please note that you are not permitted to add a new Civil Union Partner or Domestic Partner (or the children of such individual) if you dissolved a Civil Union or Domestic Partnership at any time during the prior 12 months (note that effective January 1, 2014, new Domestic Partners are not eligible under the Plan).

Continuation of Coverage

In addition to COBRA continuation coverage (discussed in *Continuation Coverage under COBRA*), coverage may be continued in the following circumstances:

Team Members on Military Leave. For team member covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed services leave, whichever is shorter, if the team member pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active team member. If the leave is longer than 30 days, the required contribution will be higher, but will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage available under COBRA continuation coverage.

Whether or not the team member elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day of his or her return to active employment with the Employer if he or she released under honorable conditions and returns to employment:

- On the first full business day following completion of military service for a leave of 30 days or less;
- Within 14 days of completing military service for a leave of 31 to 180 days; or
- Within 90 days of completing military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an illness or injury determined by the Veterans Administration to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if the team member had not taken military leave and coverage had been continuous under this Plan. Any waiting period will be waived. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the Veterans Administration). For complete information regarding your rights under USERRA, contact the Meridian HR Support Services Team.

Claims and Appeals Procedures

The Certificates may set forth their own claims and appeals procedures that differ from those that appear below. Their procedures however, must, at a minimum, meet the time periods and criteria set forth below in order to comply with applicable law. In some instances, the Certificates' procedures may provide shorter processing periods. The claims and appeals procedures set forth herein are intended to comply with the regulations of the Department of Labor set forth at 29 CFR §2560.503-1 and shall be construed accordingly.

<u>If Your Claim Is Denied</u>

If your dental benefits claim is denied in whole or in part, the Claims Administrator will notify you in writing or electronically of its determination within the time frames written below. The Claims Administrator may determine that more time is needed, but will notify you in writing if that is the case before the end of the respective claim period. If your claim is not filed properly, you or your authorized representatives will be notified of that fact and of the procedures to be followed to properly file a claim.

Urgent care claims (adverse or not) will be decided as soon as possible, but in no event later than 72 hours from receipt of the claim. If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 24 hours of receipt of the claim of

the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by the Claims Administrator, the claim will be decided within 48 hours of the earlier of:

1. the Plan's receipt of the specified information; or
2. the end of the period afforded to you to provide the specified additional information.

Concurrent care decisions to reduce or terminate ongoing treatment will be communicated in writing or electronically to you far enough in advance to give you time to appeal and obtain a determination on review before the benefit is reduced. Any request that you may make to extend the treatment beyond the Plan-specified time or number of treatments will be decided within 24 hours of receipt of your request by the Plan. However, you must make the request to extend treatment at least 24 hours before the scheduled termination or reduction in treatment. Any decision by the Plan will be conveyed to you either in writing or electronically.

Pre-service claims (adverse or not) will be decided within 15 days of receipt. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, but the Plan will notify you in writing or electronically of the circumstances causing the delay and the date a determination is expected. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

Post-service claims will be decided and communicated to you in writing or electronically within 30 business days of receipt of the claim. This determination period may be extended one time for 15 business days for reasons beyond the Plan's control, in which case the Plan will notify you in writing or electronically within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

Notice of Adverse Benefit Determinations

You will be given written or electronic notice of any adverse benefit determination on your claim. The notice will set forth:

- the specific reasons for denial;
- reference to the specific Plan provisions on which the decision is based;
- a description of any additional material or information needed for you to perfect the claim and an explanation of why the material or information is needed;
- a description of the Plan's review procedures and the applicable time limits, as well as a statement of your right to sue;
- any specific rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, etc., will be provided free, if you request a copy; and
- if the decision is based on a medical necessity and appropriate or experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free, if you request a copy.

When an urgent care decision is involved, information may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

Your Right to Appeal a Claim

The Plan maintains an appeal procedure for the resolution of disputes arising between covered persons and the Plan regarding adverse determinations.

Pursuant to your appeal, you are entitled to receive free, upon request, access to and copies of all documents, records and other information relevant to the claim. You also will receive a review that takes into account all comments, documents, records and other claim-related information. The review will be conducted by the Claims Administrator or a representative assigned by the Claims Administrator who is neither the individual who made the initial denial nor the subordinate of such individual.

If you wish to appeal an adverse determination, you have 180 days from the time you are notified to request a review. Problems as to claims between you and the Plan should generally be dealt with through the post-service

appeal procedures listed below. If you have an urgent or pre-service appeal, refer to the appeals sections below for more detailed information on the types of appeals and the process for requesting a review.

Appeal of an Adverse Benefit Determination

If you wish to appeal in writing an adverse benefit determination decision, you may submit a claim appeal. The Claims Administrator or a representative of the Claims Administrator will consult with a dental care professional, if necessary, who will neither be an individual who was consulted in connection with the initial decision nor the subordinate of any such individual. Upon request, you will be provided the identity of any dental or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether the advice was relied on to make the initial decision. The Plan representative will review your appeal, make a determination on that appeal and communicate its decision to you or your representative as described below:

- *Urgent care claims*. The Plan will notify you as to its determination of a claim involving urgent care as soon as possible but not later than 72 hours after receipt of the claim by the Plan. This is so whether or not the determination is adverse and will take into account the medical exigencies. In the event that there is insufficient information to process the claim, you will be notified, no later than 24 hours after receipt of the claim, of the need for additional information to process it. You will have 48 hours from the date of such notice to provide the requested information. Failure to provide the necessary information within the 48-hour period described above may result in the denial of the claim.
- *Pre-service claims*. Decisions on review of pre-service claims will be made and communicated as soon as reasonably possible, but in all cases within 30 days of the Plan's receipt of the claim.
- *Post-service claims*. Decisions on review of post-service claims will be made and communicated as soon as reasonably possible, but in all cases within 60 days of the Plan's receipt of the claim.

Notification of Benefit Determination on Appeal

The Claims Administrator's notice of an adverse benefit determination on appeal will include:

- the specific reason or reasons for such adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement of your right to bring a civil action under Section 502(a) of ERISA;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- any internal rule relied upon in making the adverse determination, or a statement that a copy of this information will be provided free of charge to you upon request; and
- if the adverse benefit determination was based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the adverse determination, applying the terms of the Plan to your circumstances, or a statement that such explanation will be provided free of charge upon request.

Exhaustion Requirement

You may not bring a lawsuit to recover benefits under the Plan until you have exhausted the internal administrative process described above.

Administrative (Non-Benefit) Appeals

The Plan also has a procedure for resolving disputes between you and the Plan regarding administrative, i.e., non-benefit-related matters. An example of such matters is eligibility determinations.

Direct your initial inquiry to the Plan Administrator. If you are dissatisfied with the response to your inquiry, you may appeal in writing to the Plan Administrator for an Administrative Appeal review. Presentation of a complaint should be in writing and may include written information from you or any other party in interest. This should be done as soon as possible but in no event later than 180 days from the date of the inquiry.

A Plan representative will review your appeal/grievance and respond in writing within 30 days.

Disability Claims and Appeals

The claims procedure of the Plan shall be administered in accordance with the claims procedure regulations of the Department of Labor. Accordingly, determinations of whether Plan provisions that apply to a team member or

Dependent who is disabled are applicable to such individual shall be made in accordance with the Department of Labor's claims procedure regulations applicable to claims for disability benefits, to the extent such regulations so require.

Federal Privacy Requirements

Under federal law, special rules apply to the privacy of your health information. For more information about the confidentiality of your protected health information ("PHI") and how it may be used and disclosed, please refer to the Plan's Notice of Privacy Practices (the "Notice"). The Notice explains how you may access and amend your PHI, request an accounting of disclosures of your PHI, and request restrictions on disclosures of your PHI. You may request a copy of the Notice by contacting the Plan Administrator. Other policies adopted by the Plan contain standards designed to maintain the security of your PHI.

Continuation Coverage under COBRA

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered team member, the Spouse, Civil Union Partner, or Domestic Partner of a covered team member, or a Dependent child of a covered team member. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
2. Any child who is born to or placed for adoption with a covered team member during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
3. A covered team member who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child of such a covered team member if, on the day before the bankruptcy Qualifying Event, the Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered team member is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse, Civil Union Partner, or Domestic Partner or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered team member during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Is a covered team member or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the team member,
- commencement of a proceeding in bankruptcy with respect to the employer, or
- enrollment of the team member in any part of Medicare.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium, or, for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension, up to 150% of the applicable premium. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan allows for payment only in monthly intervals.

What is Timely Payment for payment of COBRA continuation coverage? Timely payment means a payment made no later than 30 days after the first day of the coverage period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is first made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep the Plan Administrator 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.

Plan Administrator

The Board of Trustees of Meridian Health, as the Plan Administrator, has the sole and complete discretionary authority to determine eligibility for the Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Plan.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan, and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Horizon Healthcare Services, Inc. is the Claims Administrator under the Plan. Benefits will be provided only if the Claims Administrator decides in its discretion that you are entitled to them. This discretionary authority includes interpreting the terms of the group policy. The Plan Administrator determines eligibility for benefits.

Duties and Authority of the Plan Administrator

1. To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.
2. To make decisions and determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.

3. To determine the rights, eligibility, and benefits of Plan participants and beneficiaries, including deciding disputes which may arise relative to a Plan participant's rights. Benefits under this Plan will be paid only if the Claims Administrator decides in its discretion that the applicant is entitled to them.
4. To describe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Amending and Terminating the Plan

Meridian Health expects to continue the Plan, but necessarily reserves the right at any time, by or pursuant to written action of its Board of Trustees, or its delegate, to amend or terminate the Plan in any and all respects including without limitation, the right to amend the Plan to reduce, change, eliminate and/or modify the type or amount of coverage or benefits provided to any class of covered persons receiving or entitled to receive benefits, including the cost of benefits to such individual, without prior notice to such individuals. Upon termination of the Plan, all elections relating to the plan will terminate, and reimbursements and payments with respect to Plan benefits will be made only with respect to claims for expenses incurred on or prior to the date of the Plan's termination.

Your Rights under ERISA

As a participant in the Plan described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at the other specified locations, such as worksites, all documents governing the Plan, including insurance policies and contracts, if any, and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continued health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to

do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, if any, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive then within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for the benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support money order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A
LIST OF PARTICIPATING EMPLOYERS

EIN	Participating Employer
22-3471515	Meridian Hospitals Corporation
52-1772578	Meridian Nursing & Rehabilitation, Inc.
22-2715789	Bayshore Health Care Center, Inc.
52-1772578	The Willows at Holmdel
30-0107825	Meridian Health Foundation, Inc.
22-2731440	Meridian Home Care Services, Inc.
22-2581430	Health Innovations Unlimited
06-1755230	Meridian Pediatric Associates, P.C.
06-1755239	Meridian Obstetrics & Gynecology Associates, P.C.
06-1755233	Meridian Medical Associates, P.C.
77-0720131	Meridian Pediatric Surgical Associates, P.C.
06-1755228	Meridian Surgical Associates, P.C.
14-1981651	Meridian Trauma Associates, P.C.
14-1981647	Northern Monmouth County Medical Associates, P.C.
14-1981653	Northern Ocean County Medical Associates, P.C.
27-1412183	SOMC Medical Group, P.C.
22-3200147	Meridian Health Realty
22-2519699	Meridian Health Resources
22-3274755	Shore Rehabilitation Institute, Inc.
20-3411350	Health Village Imaging, L.L.C.
22-3468694	Allergy & Pediatrics Associates of New Jersey Shore, P.C.
22-3522954	Ear, Nose, Throat & Facial Plastic Surgery Associates, P.C.
22-3566714	Jersey Shore Associates in Internal Medicine of Marlboro, P.C.
22-3554900	Jersey Shore Bethany Pediatrics, P.C.
22-1892659	Jersey Shore Internal Medicine & Family Practice Associates, P.C.
22-3318056	Jersey Shore Medical Associates, P.C.
22-3607249	Jersey Shore Monmouth County Associates
22-3802205	Jersey Shore Monmouth Family Medicine Group, P.C.
22-3554905	Jersey Shore Navesink Pediatrics, P.C.
22-3668383	Jersey Shore Tinton Falls Medical Associates, P.C.
54-2074684	WLB Medical Associates, P.C.
22-3557994	Quality Care Management