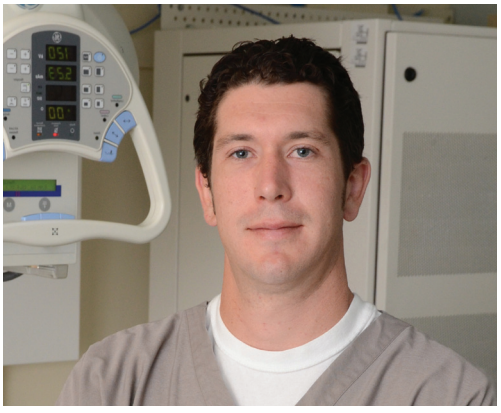
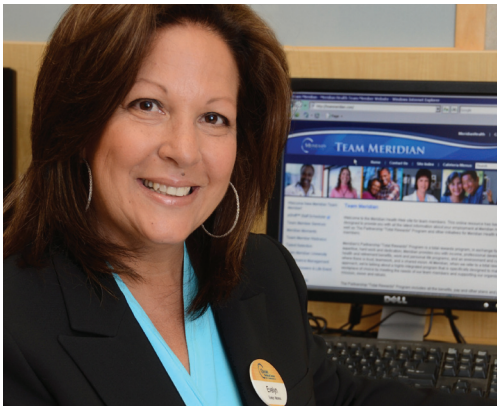
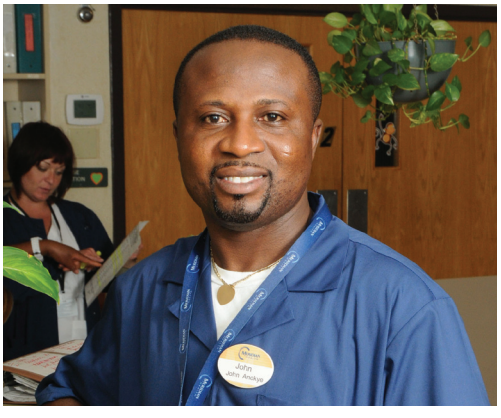
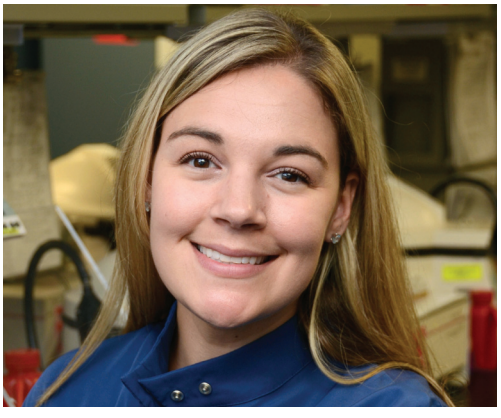
GROUP DENTAL INSURANCE









MERIDIAN HEALTH

Horizon GOLD (Dental Option Plan)

A Partnership "TOTAL REWARDS" Program

HORIZON BLUE CROSS BLUE SHIELD of NEW JERSEY

HORIZON Dental Option Plan

GROUP NAME: MERIDIAN HEALTH

GROUP NUMBER: 096194-001,041, 042

This Certificate is subject to the laws of the State of New Jersey.
Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey

DENTAL GRP 2007
COV 100

INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) dental Program gives you and your covered Dependents broad protection to help meet the costs of dental care.

In this Booklet, you'll find the important features of your group's dental benefits provided by Horizon BCBSNJ. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your Family. This Booklet replaces any booklets and/or certificates you may previously have received.

Coverage under this Program is provided according to the Group Policy for each Covered Person. Your Booklet's Schedule of Covered Services and Supplies shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts: The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place. When you become covered under the Program, you will receive a Certificate of Coverage. You should attach the Certificate of Coverage to this Booklet. Together, they form your Group Insurance Certificate.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

Horizon Healthcare Services, Inc. (d/b/a Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ))

3 Penn Plaza East
Newark, New Jersey 07105-2200

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SECTION 1 HOW THE HORIZON Dental Option Plan WORKS

Freedom Of Choice

The Horizon Dental Option Plan is designed to allow you the freedom of choice each time a Covered Person needs covered dental services, but the choices the person makes will affect the Plan's reimbursements and out-of-pocket costs. A Covered Person can choose either an In-Network Provider from Horizon's Directory of participating dentists or an Out-of-Network Provider.

In-Network Providers

In-Network Providers have an agreement with Horizon to accept Horizon's Maximum Allowable Charge as payment in full. A Covered Person will only be responsible for the Plan's deductible and/or coinsurance amounts, if any. In-Network Providers cannot balance bill for any difference between their normal charges and Our Allowance. Generally, In-Network Providers will submit a Covered Person's claims and be directly reimbursed by Horizon. Horizon In-Network Providers have agreed to discounted Maximum Allowable Charges that are significantly below their normal charges. Since both the Plan's reimbursement and a person's coinsurance amount are based on the discounted Maximum Allowable Charges, a Covered Person will minimize out-of-pocket costs when using a Horizon Dentist.

For purposes of this Plan, an In-Network Provider is a dentist who has agreed to participate in the Horizon PPO Network (Horizon PPO Dentist) as described below.

Horizon PPO Dentists: A Covered Person may choose one of the dentists who have agreed to participate in the Horizon PPO Network. Horizon PPO participating dentists have agreed to discounted Maximum Allowable Charges which are significantly below their normal charges. Since both the Plan's reimbursement and the lower coinsurance amount, if any, are based on the discounted Maximum Allowable Charges, a Covered Person will maximize the Plan's benefits and minimize out-of-pocket costs when using a Horizon PPO Dentist.

Out-of-Network Providers

An Out-of-Network Provider is any licensed Provider who does not have an agreement with Horizon. A Covered Person has the freedom to choose an Out-of-Network Provider, but since they have not agreed to any discount from their normal charges, the out-of-pocket costs may be higher. The Plan will reimburse for an Out-of-Network Provider based on the lesser of their normal charges or the Plan's Maximum Allowable Charges. A Covered Person would be responsible for not only the Plan's deductible and coinsurance amounts, if any, but any balance

the Out-of-Network Provider may bill for their normal charges that are in excess of the Plan's Maximum Allowable Charges. Since the Plan's reimbursements will be paid directly to the Employee, Out-of-Network Providers may require the entire bill to be paid in advance and require the Covered Person to submit claim forms.

How To Obtain Benefits

When a Covered Person goes to the dentist, the dental program identification card should be shown. The Covered Person should be sure to discuss charges and payment with the Provider before services begin. If submission of a Treatment Plan for any services is suggested, the Covered person should have the Provider complete the Treatment Plan portion of the claim form. Both the Covered person and the Provider will receive Our pre-determination indicating possible allowances. *This is not a guarantee of payment but an estimate of the benefits available for the proposed services to be rendered. The submission of additional claims or the revision of a pre-determined Treatment Plan prior to the final payment of this claim or changes in eligibility or plan design may affect the estimate given on the pre-determination.*

After services are completed, the dentist sends the completed claim form to us. In-Network Providers are paid directly for covered services, unless the Covered Person has already paid the dentist. If services are performed by an Out-of-Network Provider, payment for covered services may be made directly to the Employee. Whenever payment is made to the dentist, you will be notified of the amount of the payment.

In-Network Providers should have the necessary claim forms. If a dentist does not have them, a person can get them from the Group's enrollment official or from Us. See the Section 4, "Claims Procedures" for complete details on obtaining claim forms and submitting claims.

Service Centers

If a person has any questions about this Program, the person should call Our Service Center at 1-800-4DENTAL, (1-800-433-6825). Telephone personnel are available Monday through Friday from 8:00 a.m. to 6:00 p.m.

A Covered Person should always have his identification card handy when calling Us. The Employee's ID number helps Us get prompt answers to any questions about enrollment, benefits, the provider network, or claims.

Member Complaints

Members can report complaints by calling Horizon's toll-free number, 1-800-4DENTAL (1-800-433-6825). Customer Service representatives will attempt to

address and resolve the member's complaint. If a complaint cannot be resolved to the satisfaction of the member, he or she will be instructed to submit a written complaint to Horizon Healthcare, Inc., Dental Quality Management Department, P. O. Box 1710, Newark NJ 07105. Horizon will attempt to contact the involved parties to investigate the complaint. Once all pertinent information has been gathered, a resolution letter will be mailed to the member detailing the findings of the investigation and any actions taken, if necessary. If the member is not satisfied with this resolution, he or she will be instructed in the resolution letter on how and to whom to initiate a formal appeal.

Benefits From Other Plans

The benefits Horizon BCBSNJ will provide may also be affected by benefits from Medicare and other health benefit plans. Read The Coordination of Benefits section of this Booklet for an explanation of how this works.

If This Program Replaces Another Plan

The Policyholder that provides this Program may have purchased it to replace a prior plan of group dental benefits.

The Covered Person may have Incurred charges for Covered Charges under that prior plan before it ended. If so, these Covered Charges will be used to meet this Program's Deductible if:

a. they were Incurred during the Calendar in which this Program starts;
b. this Program would have paid benefits for them, if this Program had been in effect;
c. the Covered Person was covered by the prior plan when it ended and enrolled in this Program on its Effective Date; and
d. this Program starts right after the prior plan ends.

SECTION 2 DEFINITIONS

This section defines certain important terms used in this Booklet. The meaning of each defined word, whenever it appears in this Booklet, is governed by its definition below.

Act of War: Any act peculiar to military, naval or air operations in time of War.

Actively at Work or Active: Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Affiliated Company: A corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets, or as otherwise defined by the Policyholder and Horizon BCBSNJ.

Allowance: An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the Provider for the service or supply; or (b) in the case of In-Network Providers, the amount that the provider has agreed to accept for the service or supply; or (c) in the case of Out-of-Network Providers, an amount determined for the service or supply based on the 85th percentile payment based on **Fair Health Relative Value (FHRV)**.

Alternate Dental Plan: The dental plan the Group designates as an alternate to the coverage described in this Booklet.

Alternate Payee:

a. A custodial parent, who is not an Employee under the terms of this Program, of a Child Dependent, or

b. The Division of Medical Assistance and Health Services in the New Jersey Department of Human Services which administers the State Medicaid Program.

Benefit Period: The twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on the Employee's Coverage Date. The last Benefit Period ends when the Employee is no longer covered.

Benefit Year: The twelve month period beginning with the effective date as shown on the Employee's identification card and each succeeding twelve month period.

Calendar Year: A year starting January 1.

Child Dependent: A person who meets one of these conditions:

a. A person who has not attained the age of 19 is unmarried and is;

- The natural born child or stepchild of you, your Spouse or Domestic Partner , regardless of where or with whom the child lives;
- A child who is: (a) legally adopted by you, your Spouse or Domestic Partner , regardless of where or with whom such child lives; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to Horizon BCBSNJ must be furnished to us when we ask.
- You, your Spouse's or Domestic Partner , legal ward or foster child who: (a) resides with you in a regular parent-child relationship; and (b) is chiefly dependent on you for support and maintenance. But, proof of guardianship and or foster care satisfactory to Horizon BCBSNJ must be furnished to us when we ask.

b. A child otherwise defined above but who has attained age 23 and who We Determine is incapable of self-sustaining employment by reason of mental or physical handicap or developmental disability. The child will be considered a Child Dependent if the child:

- depends on you for the Employee's Spouse or Domestic Partner for most of his support and maintenance;
- had the condition before attaining age 23; and
- initially enrolled under this Policy or any other policy before reaching the age limit, and
- stayed continuously covered after reaching the age limit/when first eligible.

Note: Proof of the handicap or disability must be submitted to Us within 31 days of the date the child's coverage would otherwise end. Thereafter, periodic proof may be requested. The proof must be in a form that meets our approval.

c. A child otherwise defined above, but who has attained age 19 and who We Determine is a full-time student at an accredited institution of higher learning. The child is considered a Child Dependent until he attains age 23. Any such student who takes a qualified medical leave of absence from school, as Determined by Us, is included for coverage for up to 12 months from the last day of school attendance.

A child born to an Employee's child Dependent is not considered a Child Dependent under this Booklet.

- Proof of support, adoption, handicap, student status, and all other matters pertaining to eligibility as a Child Dependent must be submitted to Us when requested. The proof must be in a form that meets our approval.

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*

*See Rider form GRP 2007 (NJ-Civil Union HSC) at the end of the Policy for information about Civil Unions.

Clean Claim: A claim for benefits that: (a) is an eligible claim for a Covered Service or Supply rendered by an eligible Provider and furnished to a Covered Person; (b) is submitted with all the information requested by Horizon BCBSNJ on the claim form or in other instructions distributed to the Provider or Covered Person; and (c) has not been submitted fraudulently, as determined by Horizon BCBSNJ.

Coinsurance: The percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies in order to calculate benefits under the Program. These are shown in the Summary of Benefits. The term does not include Copayments. For example, if Horizon BCBSNJ's Coinsurance for an item of expense is 70%, then the Covered Person's Coinsurance for that item is 30%. Unless the context indicates otherwise, the Coinsurance percents shown in this Booklet are the percents that Horizon BCBSNJ will pay.

Copayment: A specified dollar amount a Covered Person must pay for certain Covered Services or Supplies or for a certain period of time, as described in the Summary of Benefits.

Cosmetic Services: Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Coverage Date: The date on which coverage under this Program begins for the Covered Person.

Coverage Type: Any of the different forms coverage combinations listed in the General Information Section, under the heading "Types of Coverage Available."

Covered Charges: The authorized charges, up to the Allowance, for Covered Services and Supplies. Subject to all of the terms of this Program, Horizon BCBSNJ provides coverage for charges which are Incurred for Covered Services or Supplies by a Covered Person while the person is covered by this Program.

Covered Person: You and your Dependents who are enrolled under this Program.

Covered Services and/or Supplies: The types of services and supplies described in the Summary of Benefits section of this Booklet. Except as otherwise provided in this Booklet, the services and supplies must be:

a. furnished or ordered by a Provider; and

b. Determined to be a Necessary and Appropriate Dental Service.

Deductible: The amount of Covered Charges that a Covered Person must pay before this Program provides any benefits for such charges. The term does not include Coinsurance, Copayments and Non-Covered Charges. See the Summary of Benefits section of this Booklet for details.

Dental Network: A Network of Providers, or the Covered Services and Supplies provided by a Network of Providers, who have a Dental Network Agreement with Horizon to furnish Covered Services and Supplies.

Dependent: A Spouse, Domestic Partner, or Child Dependent whom the Employee enrolls for coverage under this Program, as described in the General Information section of this Booklet.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. covered under this Program as an Employee.

No one may be a Dependent who is eligible for coverage under this Program as an Employee.

Domestic Partners: 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 evidenced 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 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 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 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 Employee and another person of the same sex as the Employee that meets the requirements set forth under this Program. Proof that such a relationship exists, as determined by Horizon BCBSNJ, must be given to Horizon BCBSNJ when requested. Horizon BCBSNJ has the right to determine eligibility for coverage under this Program.

Effective Date: The date on which coverage begins under the Policy for the Group.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to: severe pain; psychiatric disturbances; and/or symptoms of Substance Abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: (a) placing the health of the person (or, with respect to a pregnant woman, the health of the woman of her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

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.

b. Individuals who work on a temporary or substitute or seasonal basis are not considered to be Employee for the purpose of this Program.

c. 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: Collectively, all employers included under the Group Policy.

Enrollment Date: A person's Coverage Date or, if earlier, the first day of any applicable Waiting Period.

Family or Medical Leave of Absence: A period of time of predetermined length, approved by the Policyholder, during which the Employee does not work, but after which the Employee is expected to return to Active service. Any Employee who has been granted an approved Leave of Absence in accordance with the Family and Medical Leave Act of 1993 shall be deemed to be Active for purposes of eligibility for coverage under this Program.

Full-Time: Regularly employed by the Group or Affiliated Company for an average of 36 or more hours per week.

Group: The entity contracting with Us to provide coverage; and the individuals receiving coverage under this Policy.

Horizon BCBSNJ: Horizon Blue Cross Blue Shield of New Jersey.

Incurred: A charge is Incurred on the date a Covered Person receives a service or supply for which a charge is made.

In-Network: A Provider, or the Covered Services and Supplies provided by a Provider, who has an agreement to furnish Covered Services or Supplies under this Program.

In-Network Coverage: The level of coverage, shown in the Summary of Benefits, which is provided if an In-Network Provider provides the service or supply.

Late Enrollee: A person who requests enrollment under this Program more than 31 days after first becoming eligible. However, a person will not be deemed a Late Enrollee under certain conditions. See the General Information section of this Booklet for more details.

Maximum Allowable Charge (MAC): The maximum amount on which Horizon reimbursements will be based. For In-Network Providers, the Maximum Allowable Charge for any covered service is the Horizon Maximum Allowable Charge to which they've agreed. For Out-of-Network Providers, the Maximum Allowable Charge is the lesser of the Provider's normal charge for any covered service or an amount determined for the service or supply based on the 85th percentile payment based on **Fair Health Relative Value (FHRV)**.

Medicaid: The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare: Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Necessary and Appropriate Dental Services: Covered Services or Supplies that We Determine are necessary and appropriate for the treatment of the Covered Person's oral health condition and are given at the least expensive acceptable level of care as Determined by Us. We Determine Necessary and Appropriate Dental Services by review of dental literature and in consultation with the dental specialties as needed. To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or some types of trauma. The fact that a procedure is prescribed by a dentist does not make it a Necessary and Appropriate Dental Service or eligible under this Policy. Services delivered before or after they are necessary are not appropriate and are not covered. We may require proof (such as X-rays, models,

charting or narrative) to decide whether services are Necessary and Appropriate Dental Services. If a Covered Person or his dentist fails to provide this proof, We can adjust or deny payment for any services performed. For a description of the Claims Appeal process, see the Appeals Process of this Booklet.

Non-Covered Charges: Charges for services and supplies which: (a) do not meet this Program's definition of Covered Charges; (b) exceed any of the coverage limits shown in this Booklet; or (c) are specifically identified in this Booklet as Non-Covered Charges.

Open Enrollment: Enrollment during a period of at least 31 days each year, set by the Group, when an Employee may:

a. while eligible, obtain coverage under this Policy to the same extent as when first eligible after the satisfaction of any required waiting periods;

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 this Policy.

Out-of-Area Provider: A Provider outside of New Jersey.

Out-of-Network: A Provider, or the services and supplies provided by a Provider, who does not have an agreement with Horizon BCBSNJ to provide Covered Services or Supplies, depending on the context in which the term is used.

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and Supplies which is provided if an Out-of-Network Provider provides the service or supply.

Part-Time: Regularly employed by the Group for an average of but not fewer than 20 hours per week. The Group must pay the same amount toward the coverage as for Full-Time Employees.

Per Lifetime: During the lifetime of a person.

PPO Network. A Network of Providers, or the Covered Services and Supplies provided by a Network of Providers, who have a PPO Network Agreement with Horizon BCBSNJ to furnish Covered Services and Supplies.

Policy: The Group Policy between the Group and Us on which coverage under this Program is based.

Policy Year: A period of twelve months, beginning on the Effective Date of the Policy and each succeeding twelve-month period.

Policyholder: The employer or other entity that: (a) purchased the Group Policy; and (b) is responsible for paying the premiums for it.

Program: The plan of group dental benefits described in this Booklet.

Provider: A Facility or Practitioner of dental care in accordance with the terms of this Program.

Reasonable: A fee which, as Determined by Us, is justifiable considering the circumstances or dental complications of the particular case.

Service Area: The geographic area defined by the Zip Codes in the State of New Jersey and certain bordering areas.

Service Report: A claim form issued by Us showing the data concerning the Covered Person receiving services and the services rendered by the dentist.

Spouse: The person who is legally married to the Employee. Proof of legal marriage must be submitted to Horizon BCBSNJ when requested.

Total Disability or Totally Disabled: Except as otherwise defined in this Booklet, a condition wherein an Employee, due to Illness or Injury: (a) cannot perform any duty of any occupation for which he or she is, or may be, suited by education, training and experience; and (b) is not, in fact, engaged in any occupation for wage or profit. The Covered Person who is Totally Disabled must be under the regular care of a Practitioner.

Treatment Plan: A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.

Usual Fee: The fee most frequently charged for a given service by an individual dentist to his/her private patients. (i.e. his/her own usual fee).

Waiting Period: The period of time between enrollment in the Program and the date when a person becomes eligible for benefits.

We, us and our: Horizon BCBSNJ.

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.

You, your: An Employee.

SECTION 3 GENERAL INFORMATION

How To Enroll

If you meet your Employer's and Horizon BCBSNJ's eligibility rules, including any Waiting Period established by the Employer, you may enroll by completing an enrollment card. If you enroll your eligible Dependents at the same time, their coverage will become effective on the same date as your own. Except as otherwise provided below, if you or an eligible Dependent is not enrolled within 31 days after becoming eligible for the coverage under this Program, that person is deemed a Late Enrollee.

Your Identification (ID) Card

You will receive an ID card to show to the dentist or other Provider when you receive services or supplies. Your ID card shows: (a) the group through which you are enrolled; (b) your type of coverage; (c) your ID number; and (d) the Coverage Date. All of your covered Dependents share your identification number as well.

Always carry this card and use your ID number when you or a Dependent receive Covered Services or Supplies. If you lose your card, you can still use your coverage if you know your ID number. The inside back cover of this Booklet has space to record your ID number, along with other information you will need when asking about your benefits. You should, however, contact your benefits representative quickly to replace the lost card.

You cannot let anyone other than you or a Dependent use your card or your coverage.

Types Of Coverage Available

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

- **Single** – provides coverage for you only.
- **Family** – provides coverage for you, your Spouse or Domestic Partner and your Child Dependents.
- **Husband and Wife/Two Adults** – provides coverage for you and your Spouse or Domestic Partner only.
- **Parent and Child(ren)** – provides coverage for you and your Child Dependents, but not your Spouse or Domestic Partner.

Eligibility

Eligible Employees†

Subject to the terms of this Program, if You are an Employee† who is in an eligible class and have completed the Waiting Period, if any, on the Effective Date You may enroll for coverage

effective on the Effective Date. If You are a new Employee and become eligible for coverage after the Effective Date, You may enroll for coverage on the date of eligibility if You have completed the Waiting Period and if You enroll within 31 days of that date.

Eligible Dependents

Eligible Dependents may be enrolled for coverage when You enroll or, if You are already covered under this Program, if the Dependent is enrolled within 31 days of becoming eligible for coverage. A Spouse becomes eligible for coverage on the first of the month following the date of marriage. A child becomes eligible on the first date he meets the definition of Child Dependent under this Booklet. A Domestic Partner becomes eligible for coverage on the first date he meets the definition of Domestic Partner under this Booklet.

Eligibility Requirements

Employees:

You become eligible for coverage under this Program when You meet the eligibility requirements below and completes the Waiting Period, if any.

The eligibility requirements are:

a. You must be in an eligible class of individuals, as described in Schedule of Plans Active Full-Time and Permanent Part-Time Employee
b. You must not be covered as an Employee and as a Dependent under this Program.

Dependents:

A Dependent becomes eligible for coverage under this Program once: (a) You have met Your eligibility requirements; and (b) the Dependent qualifies as a Dependent under the Policy. See the "Definitions" section of this Booklet to determine a Dependent's qualification as a Spouse, Domestic Partner or Child Dependent.

ENROLLMENT AND COMMENCEMENT OF COVERAGE

Initial Enrollment

As a requirement for coverage under this Program, an individual must complete an enrollment form for himself and each of your Dependents and deliver it to the Group. The Group will then submit the enrollment form and required Premium to Horizon. The total number of Employees enrolling for coverage must meet the percentage requirements of Horizon. In order for coverage under the Policy to be effective on the date the person first becomes eligible, Horizon must receive this enrollment form on or within the time frame noted in this Booklet's Eligibility provisions.

If you do not complete an enrollment form for yourself and each of your Dependents and deliver it to the Group, which is then submitted to Horizon within the time frame noted in this Booklet's Eligibility provisions, You and each of your Dependents is a Late Enrollee.

A husband and wife or Domestic Partners who do not have eligible Child Dependents will be permitted to each enroll for Single Coverage when each Spouse or Domestic Partner is an Employee† of the Group and eligible for coverage under this Program.

When a husband and wife or Domestic Partner with eligible Child Dependents are both Employees† of the Group and each is eligible for coverage under this Program as an Employee†, either the husband or the wife or either Domestic Partner but not both will be permitted to enroll for Family or Parent and Child(ren) Coverage. The Spouse or Domestic Partner who does not opt to enroll his Dependent(s) and is not covered under the Spouse or Domestic Partner's coverage will be permitted to enroll for Single coverage.

Newborn Children

A child born to You or Your Spouse or Domestic Partner or an adopted newborn child will be automatically covered for 31 days from the date of birth.

Dental benefits may be continued beyond such 31-day period as stated below:

(a) If You are already covered for Dependent Child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

(b) If You are not covered for Dependent Child coverage on the date the child is born, You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent Child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

Adding Dependents (Other than Newborn Children)

If You are enrolled in any Coverage Type, You or the Alternate Payee must complete and submit an enrollment form to change to any other Coverage Type, to add Dependents other than when enrolling a newborn child. A change of Coverage Type may occur anytime during an Open or re-enrollment period and whenever the Employee† experiences a life event (such as marriage, adoption of a child, placement for adoption, etc.).

Even if You have Family or Parent and Child(ren) Coverage Type, Horizon must receive an enrollment form in order to add coverage for a Dependent who is not yet covered.

A change to add a Dependent will be effective on the date of eligibility if the enrollment form for this change and any additional Premium due is received within 31 days following the date the Dependent qualifies as an eligible Dependent.

Anyone who does not enroll within these stated periods will be considered a Late Enrollee.

If You are a parent who is required by court or administrative order to provide dental insurance coverage for Your Child, Horizon will: (a) permit You to enroll his or her child as a Child Dependent, without regard to any Open Enrollment restriction; and (b) will permit the Alternate Payee/Child's other parent, or the Division of Medical Assistance and Health Services as the State Medicaid agency or the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent under this Program if the parent who is the Employee ᵗ fails to enroll the Child Dependent.

Horizon BCBSNJ cannot deny coverage for your Child Dependent on the grounds that:
- The Child Dependent was born out of wedlock;
- The Child Dependent is not claimed as a dependent on your federal tax return; or
- The Child Dependent does not reside with you or in the Service Area.

If you are the non-custodial parent of a Child Dependent, Horizon BCBSNJ will:
- Provide such information to the custodial parent as may be needed for the Child Dependent to obtain benefits through this Program;

- Permit the custodial parent, or the Provider, with the authorization of the custodial parent, to submit claims for the Child Dependent for Covered Services and Supplies, without your approval; and

- Make payments on such claims directly to: (a) the custodial parent; (b) the Provider: or (c) the Division of Medical Assistance and Health Services in the Department of Human Services, which administers Medicaid, as appropriate.

If you are a parent who is required by a court or administrative order to provide dental coverage for your Child Dependent, Horizon BCBSNJ will:

- Permit you to enroll your Child Dependent, without any enrollment restrictions;
- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent in this Program, if the parent who is the Covered Person fails to enroll the Child Dependent; and
- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ with satisfactory written proof that:
- the court or administrative order is no longer in effect: or
- the Child Dependent is or will be enrolled in a comparable dental benefits plan which will be effective on the date coverage under this Program ends.

Enrollment of Late Enrollees

If you are a Late Enrollee, you may apply for enrollment for yourself and each of your Dependents only during the re-enrollment months, as specified in the Group Application. Coverage will become effective on the 1st day of the Calendar month after the Re-enrollment Effective Date.

- The above re-enrollment month must occur at least 18 months after you were last eligible for coverage. Re-enrollment opportunities will continue for the Employee ᵗ after each 18 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, as specified in the Group Application. Coverage will become effective on the re-enrollment Effective Date.

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

a. termination of employment;
b. divorce;
c. death of the Employee's Spouse or Domestic Partner; or
d. termination of the other plan's coverage.
e. a change in the number of hours worked, which changes the Employee's status from Part-time to Full-time or vice versa
f. the other coverage was under COBRA (or other state mandated) continuation provision and the COBRA or other coverage is exhausted.

We must receive your application within 31 days of termination of coverage provided under the other group's dental plan if the other coverage was under COBRA, otherwise 60 days of termination of the coverage provided under the other group's dental benefits plan.

Horizon will not consider an Employee's Spouse Domestic Partner or eligible Child Dependents for which the you initially waived coverage under this Policy to be a Late Enrollee, if the Employee is under legal obligation to provide dental coverage due to a court order. If your Spouse Domestic Partner or eligible Child Dependents are enrolled by you within 31 days of the issuance of the court order, coverage will take effect as of the date pursuant to a court order.

If the Spouse or Child Dependent is not enrolled within 31 days pursuant to a court order, then coverage will take effect the first of the Benefit Month following the enrollment of the Spouse or Child Dependent.

When Employee Coverage Starts

You must be Actively at Work and working your regular number of hours, on the date your coverage is scheduled to start. And you must have met all the conditions of eligibility which apply to you. If you are not Actively at Work on the scheduled Effective Date, Horizon will postpone the start of your coverage until you returns to Active Work.

Sometimes, a scheduled Coverage Date is not a regularly scheduled workday. However, your coverage will start on that date if you were Actively at Work and working your regular number of hours on your last regularly scheduled work day.

An Employee or Dependent (with the exception of a newborn child) who is an inpatient in a facility at the time of eligibility under this Program shall not receive coverage under this Program until the day after he is released from such a facility.

When Employee Coverage Ends

Your coverage under this Policy will end on the first of the following dates:

a. the end of the calendar month in which you (if you are an Employee) ceases to be an Actively at Work Full-Time and Permanent Part-Time Employee for any reason. Such reasons include disability, death, Retirement, lay-off, leave of absence (except for an authorized Family or Medical Leave of Absence) and the end of employment.

b. the end of the calendar month in which you stop being an eligible Employee† under this Policy.
c. the date this Program ends, or is discontinued for a class of Employee† to which the Employee† belongs.
d. the last day of the period for which required payments are made for you.

Also, you may have the right to continue certain group coverage for a limited time after your coverage would otherwise end. This section explains these situations.

If a Covered Person terminates enrollment under this dental coverage any re-enrollment must occur at least eighteen months after the Covered Person was last eligible for coverage under this Section. Re-enrollment opportunities will continue for an Employee under this Section after each 18 month interval.

When Dependent Coverage Ends

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

a. at 12:01 A.M. on the date on which the Dependent no longer meets the eligibility requirements or the definition of Dependent/Domestic Partner under this Booklet.
b. the date on which coverage for the Employee† ends, unless extended in accordance with this section.
c. the date on which the Policy ends.
d. the date Dependent coverage is terminated from this Program for all Employees† or for an Employee's† class.
e. the date an Employee† fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee† made the required payments, unless coverage ends earlier for other reasons.
f. the end of the Month in which a Child Dependent, other than a full-time student attains the maximum age for a Child Dependent.
g. the end of the Month in which a Child Dependent who is a full-time student attains the maximum age for a full-time student Child Dependent.
h. if termination is for any other reason, coverage ends at the end of the Benefit Month in which the Dependent is no longer eligible.

Voluntary Termination of a Covered Person's Coverage

Covered Persons who are otherwise eligible for coverage under this Program may request that their coverage be terminated. Coverage will end the day Horizon receives the request for termination from the Group, or on a future date/at the end of the Benefit Month for which premiums have been paid after we receive the request for termination from the Group or at the end of a future Benefit Month for which premiums have been paid, as requested by the Group.

If you are a parent who is required by a court or administrative order to provide dental insurance coverage for your Child, Horizon will not terminate coverage of the Child Dependent unless the parent who is the Employee ↑ provides Horizon with satisfactory written evidence that: the court or administrative order is no longer in effect; or the Child Dependent is or will be enrolled in a comparable dental benefits plan whose coverage will be effective on the date of the termination of coverage.

Multiple Employment

If you work for both the Policyholder and an Affiliated Company, or for more than one Affiliated Company, Horizon BCBSNJ will treat you as if employed only by one Employer. You will not have multiple coverage.

If You Leave Your Group Due To Total Disability

If you become ineligible for coverage under this Program due to Total Disability, you can arrange to continue the Program's coverage for you and your covered Dependents, if any , if:

- You were continuously enrolled under the Program for the three months immediately prior to the date your employment or eligibility ended;
- You notify your Employer in writing that you want to continue your coverage (within 31 days of the date your coverage would otherwise end);
- You make any required contribution toward the group rate for the continued coverage.

The continued coverage under this Program for you and your covered Dependents, if any will end at the first of these to occur

- Failure by you to make timely payment of any contribution required by your 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 dental plan ; or, in the case of a Dependent, the date the Dependent becomes employed and eligible for such benefits .

- The date this Program 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 this Program is also available to you (and any eligible Dependents), subject to the above requirements, if you are a Totally Disabled former Employee whose group dental coverage (for you and those Dependents) under your Employer's plan provided by another carrier was continued without interruption pursuant to state law.

NOTE: If: (a) you lose your coverage under this Program due to Total Disability; (b) you elect the continuation coverage available under COBRA (see “Continuation of Coverage under COBRA”, below) instead of the continuation coverage described in this section; and (c) your COBRA coverage terminates, the continuation coverage described in this section will still be available to you and your eligible Dependents if you: (i) request the coverage in writing within 31 days after the COBRA coverage ends; and (ii) agree to make the required contributions for the coverage.

Extension Of Coverage Due To Termination of the Group Policy

This applies if you or a covered Dependent are Totally Disabled on the date coverage under this Program ends due to termination of the Group Policy. In this event, benefits will continue to be available for that person for Covered Services and Supplies furnished within 90 days from the date coverage ends.

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.

Continued Coverage Under The Federal Family And Medical Leave Act

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 this Program. You may also continue coverage for your Dependents.

You will be subject to the same Program 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 12 weeks in any 12 month period.
- The date coverage for you or a Dependent would have ended had you not been on leave.
- Your failure to make any required contribution.

Consult your benefits representative for application forms and further details.

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 180 days after the Employee's 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 Program's coverage for the deceased Employee's class ends.

Consult your benefits representative for further details.

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 care coverage which 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 reasons other than gross misconduct;*
- You 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 Program's rules.

*(See "If You Leave Your Group Due To Total Disability" above for your continuation rights if your employment ends due to total disability.)

You or your Dependent must notify your 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 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 60 days of the later of: (a) the date the coverage would otherwise have ended; or (b) the date of the notice. You or the other person asking for coverage must pay the required amount to maintain it. The first payment must be made by the 45th 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 care coverage for other members of your class. It will continue as follows:

- Up to 18 months in the event of the end of your employment or a reduction in your hours. Further, if you or a covered Dependent are determined to be disabled, according to the Social Security Act, at the time you became eligible for COBRA coverage, or during the first 60 days of the continued coverage, that person and any other person then entitled to the continued coverage may elect to extend this 18-month period for up to an extra 11 months. To elect this extra 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 18 month continuation period; or (b) 60 days after the date the person is determined to be disabled.

- Up to 36 months for your Dependent(s) in the event of: your death; your divorce or legal separation; your 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 dental 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 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 11 months, is no longer disabled, the coverage will end on the first of the month that starts more than 30 days after that determination.

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

If you get divorced, your former Spouse may also have the option to transfer to direct payment coverage at the end of this extended period of coverage. See the “Conversion Coverage” section below.

Coordination Among Continuation Rights Provisions

If a Covered Person elects to continue his/her group dental 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, the Covered Person:

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.

SECTION 4 CLAIMS PROCEDURES

Claim forms and instructions for filing claims will be provided to Covered Persons by the Employer. Completed claim forms and any other required materials must be submitted to Horizon BCBSNJ or its designees for processing. Covered Persons do not need to file claims for In-Network Covered Services and Supplies. For Out-of-Network Covered Services and Supplies, Covered Persons have the option to file claims on his/her own behalf.

If Horizon BCBSNJ fails to furnish claim forms to the Employer for delivery to Covered Persons, or if the Covered Person fails to receive them from the Employer within 15 days after requesting them, the Covered Person making a claim will be deemed to have met the requirements for giving proofs of loss (see item b. under "Submission of Claims", below) if he/she submits written proof of loss covering the occurrence, character and extent of the loss within the time limit for submitting such proof.

Submission of Claims

These procedures apply to the filing of claims. All notices from Horizon BCBSNJ will be in writing.

a. Claim forms must be filed no later than one year after the date the services were Incurred.

b. Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service; and the charge for each service ; and the Provider's license number.

c. Horizon BCBSNJ will pay all Clean Claims no later than 30 calendar days of receipt. If the claim is not a Clean Claim, we will pay any part of it that is complete and proper according to this time limit.

d. If a claim is disputed or denied due to missing information or documentation, Horizon BCBSNJ will pay the claim within 30 calendar days after receipt of the missing information or documentation.

e. If a claim is denied or disputed, in whole or in part, Horizon BCBSNJ will notify the claimant (or his/her agent or designee) of it within 30 calendar days after receipt of the claim.

The denial notice will set forth:

1. the reason(s) the claim is denied;
2. specific references to the main Program provision(s) on which the denial is based;
3. a specific description of any further material or information needed to complete the claim, and why it is needed;
4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, we will explain why and also explain any change of coding that we make;
5. a statement of the special needs to which the claim is subject, if this is the case;

6. an explanation of the Program's claim review procedure, including any rights to pursue civil action;
7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;
8. if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and
9. the toll free number that the Covered Person or his/her Provider can call to discuss the claim.

f. If Horizon BCBSNJ does not process claims within the time frames described above, we will pay interest on the claims as and to the extent required by law.

g. This applies if an Employee is the non-custodial parent of a Child Dependent. In this case, Horizon BCBSNJ will give the custodial parent the information needed for the Child Dependent to obtain benefits under the Program. We will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without the Employee's approval.

To Whom Payment Will Be Made

a. Payment for services of an In-Network Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines. To receive In-Network coverage, a Covered Person must show his/her ID card when requesting Covered Services and Supplies from a Provider that has such an agreement.

b. Payment for services of Out-of-Network Providers will be made to you.

c. Except as stated above, in the event of a Covered Person's death or total incapacity, any payment or refund due will be made to his/her heirs, beneficiaries, trustees or estate.

d. If an Employee is the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d of the section "Submission of Claims" directly to: the Provider; or Alternate Payee/custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ makes payments to anyone who is not entitled to them under this Program, Horizon BCBSNJ has the right to recover those payments to the extent permitted by law or regulation.

Limitation of Actions

A Covered Person cannot bring a legal action against Horizon until 60 days from the date he/she files written proof of loss. He/she cannot bring legal action against Horizon after three years from the end of the time within which the proof of loss is required.

SECTION 5 APPEALS PROCESS

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal Horizon BCBSNJ's administrative and Utilization Review (UR) decisions. Administrative decisions involve benefit issues. UR decisions involve a denial, termination or other limitation of covered dental services. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

The appeal process consists of: (a) an informal internal review by Horizon BCBSNJ; (b) a formal internal review by Horizon BCBSNJ; and (c) a formal external review by an Independent Utilization Review Organization (IURO). The external review by an IURO is only available for UR decisions. Nothing in Horizon BCBSNJ's policies, procedures or Provider contracts prevents a Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) from discussing or exercising the right to an appeal.

A Covered Person must follow the steps for filing the three levels of appeal. If these steps are not followed, the Covered Person's appeal review may be delayed. Also, in the case of a Utilization Review matter, the Covered Person may be prevented from pursuing an external review. If Horizon BCBSNJ fails to comply with the appeals process or expressly waives its rights to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) may proceed directly to the formal external review.

a. First Level Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss an adverse medical decision directly with the Horizon BCBSNJ dentist who made it, or with the dental director designated by Horizon BCBSNJ. All First Level Appeals must be made within 12 months from the date that Horizon BCBSNJ informed the Covered Person of the denial of coverage or payment.

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

1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;

2) the Covered Person'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 Covered Persons of decisions about administrative First Level Appeals within 30 calendar days after receipt of the required documentation. We will inform Covered Persons of decisions about UR First Level Appeals regarding Medical Emergency or Urgent Care issues within 72 hours from receipt of the required documentation (including all situations in which the Covered Person is confined as an Inpatient), and within five business days of receipt of the required documentation for all other UR issues. Horizon BCBSNJ will provide the Covered Person and/or the Provider 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 Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level Appeal decision, the Covered Person or Provider can file a Second Level Appeal before a panel of dentists and/or other dental professionals selected by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. At the Covered Person's request, the Provider involved in the original medical decision may take part in the process.

Horizon BCBSNJ will acknowledge Second Level Appeals in writing within ten business days of receipt. We will provide written notice of the final decision on the appeal: (a) within 72 hours after receipt (in the case of UR appeals that require review on an expedited basis due to a Medical Emergency, Urgent Care or a Medical Necessity and Appropriateness issue); and (b) within 20 business days of receipt in the case of all other UR appeals.

Horizon BCBSNJ may extend the review for up to an additional 20 business days when: (a) there is a reasonable cause for the delay that is beyond Horizon BCBSNJ's control; and (b) the explanation satisfies the New Jersey Department of Health and Senior Services (DOHSS). Horizon BCBSNJ will provide the Covered Person or Provider with written notice of the delay within the original 20 day period.

If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external appeal. Horizon BCBSNJ will include specific instructions as to how the Covered Person and/or Provider may arrange for an external appeal and will also include any forms needed to start the appeal.

c. External Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results from Horizon BCBSNJ's internal appeal process can pursue an External Appeal with an IURO assigned by the DOHSS. The Covered Person's right to such an appeal depends on the Covered Person's full compliance with both stages of Horizon BCBSNJ's internal appeal process. However, if, at any time during that process, Horizon BCBSNJ fails to handle the appeal within the applicable time frame set forth in a. or b., the Covered Person or his/her designated Provider can proceed immediately to pursue the External Appeal.

To start an External Appeal, the Covered Person or Provider must submit a written request within 60 business days from receipt of the written decision about the Second Level Appeal (or within 60 business days from the last date of the filing of an appeal regarding which Horizon BCBSNJ failed to meet the required time frame set forth in a. or b., above). The Covered Person or Provider must use the required forms and include both: (a) a **$25.00** check made payable to "New Jersey Department of Health and Senior Services"; and (b) an executed release to enable the IURO to obtain all medical records pertinent to the appeal, to:

Office of Managed Care
New Jersey Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360

If the Covered Person cannot afford to pay the fee, the fee may be reduced to a **$2.00** fee if the Covered Person can show proof of financial hardship. Proof of financial hardship can be demonstrated through evidence that one or more members of the household is receiving aid or benefits under: Pharmaceutical Assistance to the Aged and Disabled; Medicaid; General Assistance; Social Security Insurance; NJ KidCare; or the New Jersey Unemployment Assistance program.

Upon receipt of the appeal, together with the executed release and the appropriate fee, the DOHSS shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for process. But, this will happen only if the DOHSS finds that:

1. the person is or was a Covered Person of Horizon BCBSNJ;

2. the service or supply which is the subject of the appeal reasonably appears to be a Covered Service or Supply under the Covered Person's Program;
3. the Covered Person has fully complied with both levels of Horizon BCBSNJ's internal appeals system; (or, alternately, that Horizon BCBSNJ failed to meet the time frames in its internal appeals system); and

4. the Covered Person has furnished all information needed by the IURO and the DOHSS to make the preliminary determination. This includes: the appeal form; a copy of any information furnished by Horizon BCBSNJ regarding its decision to deny, reduce or terminate the Covered Service or Supply; and the fully executed release.

Upon completion of this review, the IURO will immediately inform the Covered Person or Provider, in writing, as to whether or not the appeal has been accepted for review. If it is not accepted, the IURO will give the reasons. If the appeal is accepted, the IURO will complete its review and issue its recommended decision within 30 business days from receipt of all documentation needed to complete its review (or within 48 hours from such receipt, if the appeal involves emergency or urgent care).

The IURO may extend the period of review for a reasonable period of time, if it is needed due to circumstances beyond its control. But, in no event will it render its decision later than 90 calendar days following receipt of a completed application. In such an event, prior to the conclusion of the 30 business day review, the IURO will provide written notice to the Covered Person or Provider, the DOHSS and Horizon BCBSNJ describing the status of its review and the specific reasons for the delay.

When the IURO completes its review, it will state its findings in writing and make a determination of whether our denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment.

If the IURO determines that the denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment, this will be conveyed to the Covered Person and Horizon BCBSNJ. The IURO will also describe the Medically Necessary and Appropriate services that should be received. This determination is binding upon us. If all or part of the IURO's decision is in favor of the Covered Person, Horizon BCBSNJ will provide coverage for those Covered Services and Supplies that are determined to be Medically Necessary and Appropriate. If the Covered Person and/or Provider do not agree with the IURO's decision, he/she may seek the desired dental care services outside of the Program.

SECTION 6 SUMMARY OF BENEFITS

DENTAL BENEFITS

This section states the types of charges Horizon will consider as Covered Charges for Covered Services or Supplies up to its Allowance. This is subject to all the terms of this Program including, but not limited to, Determination of Necessary and Appropriate Dental Services, benefit limitations and exclusions. Horizon may require proof (such as X-rays, models, charting or narrative) to decide whether services are Necessary and Appropriate Dental Services. If a Covered Person or his dentist fails to provide this proof, Horizon can adjust or deny payment for any services performed.

ELIGIBLE BENEFITS UNDER THIS PROGRAM ARE SUBJECT TO ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUM(S) STATED IN THIS SUMMARY. THE BENEFITS ARE DETERMINED PER BENEFIT PERIOD BASED ON HORIZON'S ALLOWANCE, UNLESS OTHERWISE STATED.

REFER TO THE SECTION OF THIS BOOKLET CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.

NOTE: Members may verify coverage provided under this Program for services rendered by Out-of-Network Providers, as determined by the Group, by calling Horizon's toll-free customer service line as listed on the identification card 1-800-433-6825.

COVERED SERVICES

Except for limitations and exclusions specified in this Booklet, Horizon will provide coverage for the following services.

The following Deductible and maximums apply:

Annual Deductible - For Covered Services, other than Preventive/Diagnostic and Orthodontic coverage if eligible rendered by a PPO or Out-of-Network Provider, a Deductible of $25 for each Covered Person during each Calendar Year applies, provided that, all Covered Persons within a family are subject to a maximum aggregate Deductible of $75 during each Calendar Year. Each Deductible shall be satisfied on the basis of the first eligible services performed.

Maximum Benefits

The maximum payment by Horizon for dental services, excluding Orthodontic coverage if eligible under this Section is $1,750 for all coverage combined for each Covered Person during each Calendar Year.

Maximum Waiver of Preventive/Diagnostic Services

Charges for the following Preventive/Diagnostic Services when performed in conjunction with a prophylaxis rendered by an In-Network Provider are not counted towards the maximum payment allowed under this plan.

a. Periodic oral evaluation for an established patient.
b. Oral evaluation for patient under three years of age and counseling with primary caregiver.
c. Comprehensive oral evaluation for a new or established patient.
d. Oral prophylaxis – adult.
e. Oral prophylaxis – child.
f. Bitewing x-rays – single film.
g. Bitewing x-rays – two films.
h. Bitewing x-rays – three films.
i. Bitewing x-rays – four films.
j. Vertical bitewing x-rays – seven to eight films.
k. Topical application of fluoride (prophylaxis not included) – child.
l. Topical application of fluoride (prophylaxis not included) – adult.
m. Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

1. Preventive/Diagnostic Services

Payment for Comprehensive, limited and non-routine oral examinations and for oral prophylaxis is limited to 3 per calendar year. Payment for full-mouth X-rays is limited to once every 36 months. Payment for all remaining Preventive/Diagnostic services is limited to two per calendar year.

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 100% of the Provider's charge or 100% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 0% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of: (a) 100% of the Provider’s charge; or (b) 100% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

<u>Preventive/Diagnostic Covered Services:</u>

a. Comprehensive, limited and non-routine examinations, including consultations.
b. Bitewing X-rays and full-mouth X-rays.
c. Oral prophylaxis including cleaning/scaling and polishing.
d. Topical application of fluoride for Covered Persons under age 19
e. Sealants for Covered Persons under age 14, limited to permanent posterior molars,
f. Space maintainers , limited to treatment for premature loss of deciduous teeth and limited to Covered Persons under the age of 19

Submission of a Treatment Plan and pre-operative X-rays is suggested before space maintainer services are performed, unless done as Emergency Care.

2. Basic Restorative Services

Therapy/Treatment Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 20% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Therapy/Treatment Covered Services:

a. Repair of dentures, and bridges and crowns.
b. Fillings consisting of silver amalgam
c. Palliative emergency dental services.
d. Biopsy of oral tissue.
e. Pulp capping and pulpectomy
f. Simple extraction(s) (Submission of Pre-operative X-rays and a Treatment Plan is suggested for three or more extractions).
g. Endodontics, root canal therapy, Anterior and Bicuspid
h. Endodontics, root canal therapy, Molar
i. Onlays for restorative purposes (not part of a bridge or splinted). No benefits are provided for: 1. Replacement of onlays within 5 years of insertion, 2. Replacement of any onlay that is functional or could be made functional, 3. Single, unconnected onlays if the tooth can be restored by any other material. If Horizon decides the tooth can be restored with another material, payment will be the allowance toward the charge for onlay. 4. Each tooth is limited to a single cast restoration once per 5 years.

j. Retention Pins
k. Sedative Fillings
l. Pulp Vitality Test

For coverage eligible under paragraphs g., and h, above, submission of a Treatment Plan and pre-operative X-rays is suggested before the services are performed, unless they are done as Emergency Care. For coverage eligible under paragraph g., post-operative X-rays may be clinically necessary.

Oral Surgery Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 20% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Oral Surgery Covered Services:

Oral Surgery coverage will be provided as follows:

a. Alveoplasty as a separate service if performed in conjunction with 3 or more extractions.
b. Extraction(s) (Submission of Pre-operative X-rays and a Treatment Plan is suggested for three or more extractions)
c. Surgical extractions (Submission of a Treatment Plan is suggested for three or more extractions)
d. Surgical extractions, Partial Bony (Submission of a Treatment Plan is suggested for three or more extractions)
e. Surgical extractions, Complete Bony (submission of a Treatment Plan is suggested for three or more extractions)
f. Treatment of fractures
g. Removal of lesions
h. Apicoectomy
i. Appliances for minor tooth movement (Submission of a Treatment Plan and pre-operative X-rays is suggested *before* the services are performed, unless done as Emergency Care)
j. Dentally necessary general anesthesia, for a covered dental service, when administered and billed for by a licensed dentist or physician, other than the operating

dentist, or by a certified registered nurse anesthetist employed by and personally supervised by a dentist anesthesiologist. This includes the administration of anesthetics by injection or inhalation, but not local anesthesia. Examinations, consultations and other necessary care an anesthesiologist gives-before during and after the operation-are all included in the payment for anesthesia service.

k. Biopsy of oral tissue when not in conjunction with a more definitive service, exclusive of laboratory fees.

For coverage under subparagraphs c. through l. above, it is suggested that pre-operative X-rays be sent with the claim, except for removal of soft-tissue tumors.

Periodontic Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 20% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 80% of the Provider's charge or 80% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Periodontic Covered Services:

Periodontic coverage will be as follows:

a. Periodontal prophylaxis
b. Management of acute infections and oral lesions
c. Gingivectomy and gingivoplasty
d. Osseous surgery, including flap entry and closure. Any periodontal surgical procedure performed on the same date as osseous surgery will not be an eligible service
e. Mucogingival surgery
f. Periodontal maintenance procedures, following active therapy and provided a period of at least three months has elapsed since surgery was performed. Only two periodontal maintenance visits or two oral prophylaxis or combination of one periodontal maintenance visit and one oral prophylaxis will be eligible in any twelve consecutive month period oral prophylaxis will be eligible in any twelve consecutive month period.
g. Occlusal adjustments, but only when performed with history of definitive periodontal treatment.
h. Guided Tissue Regeneration (GTR)

i. Other periodontal procedures as Determined by Horizon
j. Periodontal Root Planning, once every 12 months.

For coverage eligible in subparagraphs e through g. above, submission of a Treatment Plan including pre-operative X-rays and periodontal charting is suggested. For coverage eligible in subparagraph a. above, submission of a Treatment Plan is suggested.

3. Major Services

Onlays And Crown Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 50% of the Provider's charge or 50% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 50% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 50% of the Provider's charge or 50% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Onlays and Crown Covered Services:

Onlays and crowns for restorative purposes (not part of a fixed bridge or for splinting purposes) and are covered except as stated below.

No Onlay and Crown coverage will be provided for:

a. Replacement of crowns or onlays within 5 years after insertion under this Section;

b. Replacement of any onlay or crown that is functional or could be made functional without replacement;

c. Single, unconnected crowns and onlays if the tooth can be restored by any other material. If Horizon Determines the tooth can be restored with a less expensive restorative material, payment for the alternate benefit will be applied toward the charge for the single cross or onlay.

Prosthodontic Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 50% of the Provider's charge or 50% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 50% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 50% of the Provider's charge or 50% of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Prosthodontic Covered Services:

Prosthodontic services are provided as follows:

a. Removable Partial or complete dentures;
b. Fixed bridges and retainer crowns.
c. Denture Adjustments.

Submission of a Treatment Plan and pre-operative X-rays is suggested *before* these services are performed.

No Prosthodontic coverage will be provided for:

a. Replacement of dentures or bridges within 5 years after insertion/receiving them under this Section
b. Replacement of dentures or bridges due to loss or theft
c. Replacement of any denture or bridge that is satisfactory or functional or can be made satisfactory or functional
d. Any specialized appliances, including overdentures, ridgebars and precision attachments
e. Relining or rebasing initial or replacement dentures if the services are performed within six months after insertion of the dentures or for more than one relining or rebasing in any 36-month period

Missing Teeth Coverage:
Dentures or bridges made to replace permanent, naturally occurring teeth that were missing prior to the Covered Person's coverage under this Section became effective are eligible for payment. †

4. Orthodontic Services

Payment for Covered Services when provided by an In-Network Provider shall be:

- The lesser of 50% of the Provider's charge or 50% of the Maximum Allowable Charge as Determined by Horizon. An In-Network Provider may bill the Covered Person for the remaining 50% and shall accept payment of the total of the two percentage amounts and the Deductible, if applicable, as payment in full and make no additional charge for the Covered Services.

Payment for Covered Services when provided by an Out-of-Network Provider shall be:

- The lesser of 50 % of the Provider's charge or 50 % of the Maximum Allowable Charge as Determined by Horizon. Horizon shall not be liable for any balance.

Any Deductible required under this Section does not apply.

No more than $1,000 in coverage will be paid for any Covered Person during any Lifetime .

For orthodontic treatments expected to extend beyond six months, Horizon will pay the lesser of 50 % of the orthodontic maximum or 50 % of the total orthodontic charge when eligible orthodontic appliances are initially inserted on a covered person. At 6 months intervals, Horizon will make additional payments to the orthodontist or member until any maximum is reached. The sum of these payments will represent Horizon's full liability for the orthodontic case. These payments are made only for services performed while the covered person insured. If insurance or treatment ceases during a period, the amount payable for that period will be pro-rated. For orthodontic treatments expected to be six months or less, full payment will be made when eligible orthodontic appliances are initially inserted on a covered person.

Orthodontic Covered Services:

a. Orthodontic services are provided as follows according to the Treatment Plan:

   1. One diagnosis and treatment per Lifetime
   2. Active treatment including appliances
   3. Retention treatment to a maximum of five Visits during the period of time specified in the Treatment Plan

b. No Orthodontic Coverage is provided for:

   1. Additional orthodontic coverage provided within 5 years of completing previously eligible treatment
   2. Services to a Covered dependent who is a full-time student after the last day of the Policy month in which the person attains age 23

3. Orthodontic treatment beyond the period of time specified in the Treatment Plan. The maximum number of months for which coverage is provided for active or retention treatment will be reduced by the number of months of treatment performed before the Effective Date of this coverage
4. Separate charges for the replacement or repair of any appliance furnished under the Treatment Plan.
5. Charges for orthodontia procedures in connection with an active appliance that was installed before the first day on which the orthodontia benefit became effective or the Covered Person became effective under Horizon.

c. For Late Enrollees benefits will not be provided for services begun earlier than 6 months after the Effective Date of the Covered Person's coverage under this Policy.

d. In the event any of the orthodontia provisions contained in this Section are changed, the new provisions will only apply to orthodontia procedures in connection with an active appliance that was installed after the date of the change.

e. A Treatment Plan is prepared by the dentist in connection with the recommended orthodontic services. Preapproval of the Treatment Plan is not required, and claims will not be denied for failure to receive Preapproval. It is suggested for the benefit of the Covered Person, to give the Covered Person an estimate of the benefits available under this Policy for the proposed services.

To Whom Payment Will Be Made

For eligible services under this Section provided by an In-Network Provider, Horizon shall make payment to the dentist unless the dentist certifies that his fee has been paid, in which case payment will be made to the Employee.

For eligible services under this Section provided by an Out-of-Network Provider, Horizon shall make payment to the Employee.

When the charge for eligible services is made directly or indirectly by a corporation, hospital, clinic, or group which includes other than In-Network Providers, payment shall be made to the Employee.

Out-of-Network Provider Payment Level

The Maximum Allowable Charge for services provided by an Out-of-Network Provider is based on the 85th percentile payment based on the data provided by Fair Health Relative Value (FHRV).

Conditions under Which Dental Services Are Rendered

The Covered Person shall notify the dentist that he is covered under this Section prior to treatment. Horizon is liable only when the Covered Person and the dentist providing the

services have properly completed, signed and submitted to Horizon the Service Report. The Service Report shall be sent to Horizon within 12 months after the services have been completed. If the Service Report is not submitted within the 12 months and it can be shown that it was not reasonably possible to do so, the claim will not be invalidated if the Service Report is submitted as soon as it is reasonably possible.

SECTION 7 COVERAGE LIMITATIONS

Your Program will share the cost of the dental expenses Incurred by a Covered Person. This section explains certain limitations on your coverage.

NOTE: Members may verify coverage provided under this Program for services rendered by Out-of-Network Providers, as determined by the Group, by calling Our toll-free customer service line as listed on the identification card 1-800-4DENTAL, (1-800-433-6825).

BENEFIT PROVISIONS

The Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Deductible before Horizon provides coverage to that person. The Deductible is shown in the Summary of Benefits. The Deductible cannot be met with Non-Covered Charges. Only Covered Charges Incurred by the Covered Person while covered by this Program can be used to meet this Deductible.

Once the Deductible is met, Horizon provides benefits, up to its Allowance, for other Covered Charges above the Deductible Incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. However, all charges must be Incurred while that Covered Person is covered by this Program; and what coverage Horizon provides is based on all the terms of this Program.

Family Deductible Limit

This Program has a family Deductible limit of 3 Deductible(s) for each Calendar Year. Once 3 Covered Persons in a family meet their individual Deductibles, or aggregately combine to meet 3 times the individual Deductible, in a Calendar Year, Horizon provides benefits for other Covered Charges Incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What coverage Horizon provides is based on all the terms of this Booklet.

Payment Limits

Horizon limits what it will pay for certain types of charges. See the Summary of Benefits section for these limits.

Benefits From Other Plans

The benefits Horizon will provide may also be affected by benefits available from Medicare and other health or dental benefit plans. Read the Coordination of Benefits section for an explanation of how this works.

Dental Limitations

a. If there are less expensive acceptable methods of treatment (e.g., varying techniques and appliances) which methods carry different Allowances, Horizon shall not make payments in excess of the lesser Allowance, unless a method carrying a greater Allowance is the only adequate treatment.

b. If a Covered Person transfers from the care of one dentist to that of another dentist during a course of treatment, or if more than one dentist performs services for one dental procedure, Horizon shall not pay more than the amount it would have paid if one dentist performed all the services during each course of treatment.

c. If the nature or extent of a given service must be determined, this determination is entirely up to Horizon. This includes determining whether services are Emergency Care and determining whether a dentist gave services.

d. Horizon will make payment for non-orthodontic services only after they have been completed. If any payment has been pre-determined based on a Treatment Plan, Horizon has the right to change that amount. This change may be necessary because of mathematical error, or because of a change in coverage. If treatment is completed before the time specified in a pre-determined Treatment Plan, Horizon will pay any amount due for Covered Services after notification by the dentist.

e. The total amount payable for all expenses incurred for orthodontics during a Covered Person's Lifetime will not be more than the maximum shown in the Schedule of Benefits.

Payments for orthodontic treatments are made in installments. Payment of benefits will be made in four installments. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 6 month period. In determining the first installment, Horizon assigns 33% of the charge for the entire course of treatment to the appliance. The remainder of such charge is prorated over the estimated duration of the orthodontic treatment. These payments will represent Horizon’s full liability for the orthodontic case. These payments are made only for services performed while a person is insured. If insurance or treatment on a Covered Person ceases during a period, the amount payable for that period will be prorated.

SECTION 8 EXCLUSIONS

The following are not Covered Services and Supplies under this Program. Horizon BCBSNJ will not pay for any charges incurred for, or in connection, with:

Any part of a charge that exceeds the Allowance.

Balances for services and supplies after Payment has been made under this Policy.

Copayments, Deductibles, and the individual's part of any coinsurance; expenses Incurred after any Payment, duration or visit maximum is or would be reached.

Completion of claim forms.

The services of an assistant surgeon or assistant dentist.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise provided in this Booklet.

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 or 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.

Personal comfort and convenience items.

Services required by an Employer as a condition of employment; services rendered through a medical department, clinic, or other similar service provided or maintained by an Employer.

Services or supplies:

- eligible for payment under either federal or state programs (except Medicare Part B and Medicaid when, by law, this Program is primary). This provision applies whether or not the Covered Person asserts his/her rights to obtain this coverage or payment for these services;

- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

- for which the Provider has not received a certificate of need or such other approvals as are required by law;

- for which the Covered Person would not have been charged if he/she did not have dental benefits;

- needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation;

- 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;

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the Injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) 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 Covered Person is serving in such forces and is outside the Home Area;

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person 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 (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area;

- provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area;

- which are specifically limited or excluded elsewhere in this Booklet;

- for which a Covered Person is not legally obligated to pay.

The following services and materials:

- Any services by a dentist which are not specifically listed as covered under this Booklet

- Replacement of tooth structure lost due to attrition, abrasion or erosion

- Educational services, such as oral hygiene or dietary instructions

- Services in connection with plaque control programs, except oral prophylaxis

- Replacement of lost, stolen or broken space maintainers

- Missed or broken dental appointments

- Sterilization fees

- Gold foil restorations

- Inlays

- Services performed by a dental department or clinic of an employer, labor union, or similar group

- Services performed or items furnished strictly for cosmetic purposes. Facings on crowns, or pontics, that are behind the second bicuspid will always be considered cosmetic unless as a result of accidental injuries sustained while a Covered Person

- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting

- Services related to myofunctional therapy

- Services relating to Temporal Mandibular Joint (TMJ) Syndrome

- Implants, related appliances and services or the surgical removal of an implant

- Orthognathic surgery

- Teeth extracted or missing prior to the effective date of coverage

- Services to alter vertical dimension to occlusion

Services if they are performed by any of the following:

1. A Hospital resident, intern or dentist who is paid by a hospital or other source, or who is permitted to charge for services covered under the Summary of Benefits Section of this Policy. Services performed by such persons are excluded whether or not the person is in training.

2. Anyone who does not qualify and is not licensed as a dentist.

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

- Services or supplies provided to the Covered Person prior to the Covered Person's effective date of coverage or after the date the Covered Person is no longer eligible for benefits

- Services that are performed by an immediate relative of the Covered Person or who ordinarily resides with the Covered Person unless specifically stated in the Summary of Benefits. An immediate relative is defined as the Covered Person's Spouse, Child(ren), parent, in-law, brothers or sisters.

- Services with fees payable to a Hospital or other institution; all hospital services; Accidental Injury/Accident or any procedures which are covered under another plan established by the Group which provides group hospital, surgical, or medical benefits, whether or not on an insured basis

- Anesthesia or consultation services performed in connection with any service that is not covered

- Services that do not meet the Necessary and Appropriate Dental Services level of care requirements of this Booklet.

SECTION 9 COORDINATION OF BENEFITS AND SERVICES

PURPOSE OF THIS PROVISION

A Covered Person may be covered for dental benefits or services by more than one plan. For instance, he or she may be covered by this Program as an Employee and by another plan as a Dependent of his or her Spouse or Domestic. If he or she is, this provision allows Horizon BCBSNJ to coordinate what Horizon BCBSNJ 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 Covered Person is covered.

DEFINITIONS

The terms defined below have special meanings when used in this provision. Please read these definitions carefully. 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 Covered Person is liable when the dental 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 this Program is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

When this Program is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Horizon BCBSNJ 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 Covered Person 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 dental provider organization (DPO) 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 a DPO 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;

Primary Plan: A Plan under which benefits for a Covered Person'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 Covered Person use order of benefit determination rules consistent with those contained in the 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 Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a Covered Person 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 BCBSNJ 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 Medically Necessary and Appropriate services and supplies on the basis that pre-authorization, Pre-Approval, or Second Surgical Opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Covered Person as an Employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Covered Person as a Dependent. The coverage as an Employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the Covered Person 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 Covered Person 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 Covered Person 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 Covered Person 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, or Domestic 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, or Domestic 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 dental 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 dental 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, subscriber or retiree 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 Provider 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 Provider bills a charge and the Covered Person 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 Provider, called an In- Network Provider, bills a charge, the Covered Person 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 Covered Person uses the services of an Out-of-Network Provider, 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 Provider may be based on a "capitation." This means that the carrier pays the Provider a fixed amount per member. The Covered Person is liable only for the applicable Deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

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

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

If the Provider is an In-Network Provider 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 Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

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

If the Provider is an In-Network Provider 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 Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay 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 Covered Person receives services or supplies from a Provider 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 Covered Person receives services or supplies from a Provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan.

SECTION 10 BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

This section applies when expenses are Incurred by a Covered Person due to an Automobile Related Injury.

Definitions

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

"Allowable Expense": A Medically Necessary and Appropriate, 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 or Copayments, if any.

"Out-of-State Automobile Insurance Coverage" or "OSAIC": Any coverage for medical 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 this Program's health coverage has been elected as primary by or for the Covered Person. 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 insureds under other auto contracts. This Program may be primary for one Covered Person, but not for another if the persons have separate auto contracts and have made different selections regarding the primacy of 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 Covered Person's other health benefits. In that case, this Program is primary.

If the above rules do not determine which health coverage is primary, or if there is a dispute as to whether this Program is primary or secondary, this Program will provide benefits for Covered Charges 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 Charges in accordance with its terms. If there are other plans that: (a) provide benefits to the Covered Person; 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 Deductibles, Copayments, and/or Coinsurance); or
b. the actual benefits that this Program would have paid if it provided its coverage primary to PIP.

SECTION 11 GENERAL RULES

A. AMENDING THE POLICY

This Policy may be amended at any time without the consent of Covered Persons or anyone else with a beneficial interest in it. This can be done through written request that is: (a) made by the Policyholder at least 60 days in advance of the proposed effective date; and (b) agreed to by Horizon BCBSNJ. But, an amendment that changes benefits under a Coverage will not affect claims Incurred before the date of the change.

Only an authorized officer of Horizon BCBSNJ has the power, on behalf of Horizon BCBSNJ, to: (a) waive any condition or restriction of the Policy; (b) to extend the time in which a Premium may be paid; or (c) to make any other change in the Policy.

No change in the Policy is valid unless shown in: (a) an endorsement signed by an authorized officer of Horizon BCBSNJ; or (b) an amendment to it signed by the Policyholder and an officer of Horizon BCBSNJ.

However, there are certain changes that may be made automatically in an amendment or endorsement to the Policy that is signed only by an officer of Horizon BCBSNJ. For example, Horizon BCBSNJ may amend the Policy in this manner as described in Subsection "C. Premium Rate Changes" of the Section "Premiums", or to change an address or phone number. However, except as needed to meet the requirements of a state or federal law or regulation that applies to the Policy, Horizon BCBSNJ will not amend the Policy in this manner to: (a) change Covered Services and Supplies; amounts payable; Deductibles; exclusions; frequency limits; or maximums, or (b) change general policy provisions (e.g., eligibility requirements, termination provisions, coordination of benefits, appeal rights, etc.). Furthermore, except for revisions needed to meet the requirements of a state or federal law or regulation or minor administrative changes, no such unilateral change will be made: (i) without at least 30 days advance notice; and (ii) as of any date other than an Anniversary Date. No changes may be made unless the revised text has been approved by the New Jersey Department of Banking and Insurance.

B. ASSIGNMENT

An assignment or transfer of the Policyholder's interest under this Policy will not bind Horizon BCBSNJ without Horizon BCBSNJ's advance written consent to it.

C. CERTIFICATES OF COVERAGE

Horizon BCBSNJ will give the Policyholder an individual certificate to give to each insured Employee. It will describe the Employee's insurance under the Policy. It will include: (a) to whom Horizon BCBSNJ pays benefits; (b) any protection and rights when the insurance ends; and (c) claim rights and requirements.

D. CLERICAL ERRORS; MISSTATEMENTS

Horizon BCBSNJ's errors in keeping records pertaining to coverage under this Policy, or Horizon BCBSNJ's delays in making entries about those records, will not: (a) invalidate coverage that would otherwise be in force, or (b) serve to continue coverage that would otherwise have ended. But, if such an error or delay occurs, Horizon BCBSNJ will make an equitable adjustment in Premium.

Horizon BCBSNJ shall be liable to the Policyholder for any Premium adjustments involving a return of unearned Premium to the Policyholder, to the extent that Horizon BCBSNJ determines such adjustments to be warranted.

If a Policyholder's clerical error causes coverage to be provided under this Policy that would not have been provided if the error did not occur, the Policyholder shall be liable to Horizon BCBSNJ for the cost of any and all claims paid by Horizon BCBSNJ due to the error before the date that the error was discovered.

If: (a) an age or any other relevant fact about a person is used to determine the Premium for the person's insurance under this Policy; and (b) the age or that fact is found to be in error; and (c) the error affects the Premium, the Premium will be adjusted to reflect the correct age or fact. If the error involves whether or not the person would be covered under this Policy, or the amount of the person's coverage, the true facts will be used to determine if such coverage is in force, and in what amounts, subject to the Policy's Incontestability provision.

E. CONFORMITY WITH LAW

Any provision of this 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.

F. CONTINUING RIGHTS

Horizon BCBSNJ's failure to apply terms and conditions of this Policy does not mean that Horizon BCBSNJ waives or gives up any future rights under this Policy.

G. END OF THE GROUP POLICY

Horizon BCBSNJ has the right not to renew this Policy, subject to any statutory notification or other requirements, if:

a. Horizon BCBSNJ ceases to do business in the large group market or to offer the type of insurance provided under the Policy;

b. the Policyholder fails to meet this Policy's participation rules, as set forth under K. "Participation Rules", below.

<u>During or at End of Grace Period- Failure to Pay Premiums</u>:

If any premium is not paid by the end of its Grace Period, this Policy will automatically end when that period ends. But, the Policyholder may write to Horizon BCBSNJ, in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid, or at any time during the grace period. If that occurs, this Policy will end on the date requested. The Policyholder is liable to pay premiums to Horizon for the time this Policy is in force.

Horizon BCBSNJ also has the right to cancel this Policy subject to 30 days advance written notice to the Policyholder if the Policyholder commits fraudulent acts or makes misrepresentations about persons eligible for insurance under the Policy.

Horizon BCBSNJ's right to end this Policy is not affected by the health of anyone covered under it. This means that any Illness, Injury, or other condition that any Covered Person may have will not limit Horizon BCBSNJ's right to end this Policy. But, Horizon BCBSNJ cannot end this Policy due to health status-related factors of any Covered Person.

The Policyholder may end this Policy or a Coverage under it as of any Anniversary Date of the Policy. If the Policyholder wishes to terminate the Policy or Coverage under it on other than an Anniversary Date, the Policyholder must give Horizon BCBSNJ 30 days advance written notice. If the Policyholder does not provide the 30 days advance notice, the Policyholder must reimburse Horizon BCBSNJ in full for all claims Incurred and paid under the Policy or Coverage after termination date and until 30 days after receipt of the written notice. Horizon Healthcare agrees to document these paid claims via a detailed claims listing. The Policyholder agrees to reimburse Horizon BCBSNJ within 30 days of being billed. Late payment charges will be assessed for each day payment is made beyond the due date.

H. IDENTIFICATION CARDS

Any identification cards ("ID cards") issued by Horizon BCBSNJ in connection with the insurance under the Policy are for identification only and remain the property of Horizon BCBSNJ. Possession of an ID card does not convey any rights to benefits under the Policy. If any Covered Person permits another person to use the Covered Person's ID card, Horizon BCBSNJ may invalidate that Covered Person's ID card.

I. INDEMNIFICATION BY THE POLICYHOLDER

The Policyholder shall indemnify, defend and hold Horizon BCBSNJ harmless against any of the following that occur due to the imposition of imputed income to Same-Sex Domestic Partners insured under the Policy: (a) claims; (b) liability; (c) damages; (d) costs; and (e) expenses.

J. NOTICES AND OTHER INFORMATION

Any notices, documents or other information regarding this Policy may be sent by U.S. mail, postage prepaid, addressed as follows:

If to Horizon BCBSNJ: To the last address on record with the Policyholder.

If to the Policyholder: To the last address of the Policyholder on file with Horizon BCBSNJ.

K. PARTICIPATION RULES

There must be at least 51 Employees eligible for coverage under this Policy. Also, at least 75% of the Employees eligible for insurance must be enrolled for coverage. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a dependent under a Spouse's coverage, other than individual coverage; or

b. the Employee is covered under any dental benefits plan offered by the Employer; or

Horizon will count that Employee as being covered by this Policy for the purpose of meeting participation rules.)

L. THE POLICY; INCONTESTABILITY OF THE POLICY; CLAIMS

The entire Policy consists of: (a) the certificate(s) of coverage listed in the Schedule of Plans, copies of which are attached to this Policy; (b) all modifications, amendments, endorsements and riders which are attached to and made a part of the Policy; (c) the Policyholder's application, a copy of which is attached to the Policy; and (d) the individual applications or enrollment forms, if any, of the persons insured. Statements made by the Policyholder or Covered Persons shall be deemed representations and not warranties. No statement of the Policyholder or Covered Persons shall be used in any contest of the insurance under the Policy unless contained in a written statement signed by the insured.

There will be no contest of the validity of the Policy after it has been in force for one year, except: (a) for not paying Premiums; or (b) if the Policyholder commits fraudulent acts or makes misrepresentations about persons eligible for insurance under the Policy.

Either the Policyholder or Horizon BCBSNJ, as they agree, will keep a record of the insured Employees. It will contain the key facts about their insurance.

Horizon BCBSNJ will furnish claim forms to the Policyholder for delivery to Covered Persons. If the Covered Person does not receive such forms within 15 days of Horizon BCBSNJ's receipt of notice of claim, timely written proof covering the occurrence, character, and extent of loss shall be accepted in lieu of the claim form.

M. RECORDS - INFORMATION TO BE FURNISHED

At the times set by Horizon BCBSNJ, the Policyholder will send the data required by Horizon BCBSNJ to perform its duties under the Policy, and to determine the Premium

rates. All records of the Policyholder or of an Affiliated Company, if any which bear on the insurance must be open to Horizon BCBSNJ for its inspection at any reasonable time.

Horizon BCBSNJ will not have to perform any duty that depends on such data before it is received in a form that satisfies Horizon BCBSNJ. The Policyholder must correct wrong data given to Horizon BCBSNJ. An Employee's insurance under the Group Policy will not be made invalid by failure of Horizon BCBSNJ or the Policyholder, due to clerical error, to record or report the Employee for that insurance.

The Policyholder must notify Horizon BCBSNJ, within 60 days, of any event, including a change in eligibility, that causes a Covered Person's insurance under a Coverage to end. If this is not done, the applicable procedure for crediting Premiums described in Section "B. Premium Amounts" of form DENTAL GRP 2007 will apply.

If at any time Horizon BCBSNJ requests verification and/or evidence of a Covered Person's eligibility for the insurance under a Coverage, that information must be furnished in writing within 14 days after the date of the request.

N. RELATION BETWEEN HORIZON BCBSNJ AND THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Policyholder, on behalf of itself and its participants, agrees and understands that this Policy is solely between the Policyholder and Horizon BCBSNJ. Horizon BCBSNJ is an independent corporation that operates under a license from the Blue Cross and Blue Shield Corporation, an association of independent Blue Cross and Blue Shield Plans (the "Association"). This permits Horizon BCBSNJ to use the Blue Cross and Blue Shield Service Marks in New Jersey. Horizon BCBSNJ is not an agent of the Association.

The Policyholder, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon any representations by any person other than Horizon BCBSNJ. The Policyholder also acknowledges and agrees that no person, entity or organization other than Horizon BCBSNJ shall be held liable to the Policyholder for any of Horizon BCBSNJ's obligations to the Policyholder. This provision shall not create any additional obligations on the part of Horizon BCBSNJ other than those created under this Policy.

O. RELATION AMONG PARTIES AFFECTED BY THE POLICY

The relationship between Horizon BCBSNJ and any In-Network Provider is that of an independent contractor. No In-Network Provider is an agent or employee of Horizon BCBSNJ, nor is Horizon BCBSNJ or any employee of Horizon BCBSNJ an employee or agent of any In-Network Provider. Each In-Network Provider will maintain the Provider-patient relationship with Covered Persons under the Policy and is solely responsible to Covered Persons for services and supplies furnished to Covered Persons.

Neither the Policyholder nor any Covered Person under the Policy is the agent or representative of Horizon BCBSNJ. Neither the Policyholder not any Covered Person under the Policy will be liable for any acts or omissions: (a) of Horizon BCBSNJ, its agents or employees; or (b) of any Hospital or other Provider with which Horizon BCBSNJ, its agents or employees make arrangements for furnishing services and supplies to Covered Persons.

P. TERM OF POLICY-RENEWAL

This Policy is issued for a term of 12 months from the Effective Date shown on the first page of this Policy. All Policy terms and coverage months will be calculated from the Effective Date. All periods of coverage will begin and end at 12:00:01 a.m. EST.

The Policyholder may renew this Policy for a further term of one year, on the first and each later Policy Anniversary. All renewals are subject to the payment of premiums then due.

SECTION 12 COVERED PERSONS' RIGHTS

A Covered Person has the right to:

- Formulate and have advance directives implemented in accordance with applicable law;
- Receive prompt written notice of benefit changes or the termination of benefits or services, no later than 30 days following the date of any such change or termination;
- File a complaint with New Jersey's Department of Health and Senior Services and/or the Department of Banking and Insurance;

New Jersey Department of Banking and Insurance
20 West State Street
P.O. Box 325
Trenton, NJ 08625-0325
(609) 292-5360

Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360
(609) 292-7837

- Access Covered Services and Supplies, and receive the Program's benefits for them, and have care available 24 hours a day, seven days a week, for Urgent Care;
- Appeal a denial, reduction or termination of health care services or benefits pursuant to a utilization management decision by or on behalf of Horizon BCBSNJ;
- Be treated with courtesy, consideration, and with respect to his/her dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures, and with other information about the organization and the care provided;
- Obtain a current directory of In-Network Providers upon request, including addresses and telephone numbers, and a listing of Providers who accept Covered Persons who speak languages other than English.

STATEMENT OF ERISA RIGHTS

As a participant in MERIDIAN HEALTH, 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 other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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 Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a 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 dental coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group dental plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or dental 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 pre-existing 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 employee 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, 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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a 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 were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a 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 is frivolous.

Assistance with Your Questions

If your have any questions about your 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HORIZON HEALTHCARE SERVICES, INC
CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Employee. Your Booklet's Schedule of Covered Services and Supplies shows the Group Policyholder and the Group Policy Number.

Insured Employee: You are insured under the Group Policy. Attach this Certificate of Coverage to your Booklet. Together, they form your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

Horizon Healthcare Services, Inc.
3 Penn Plaza East
Newark, New Jersey 07105-2200

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