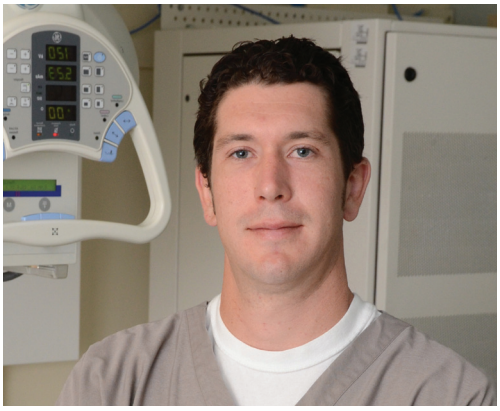
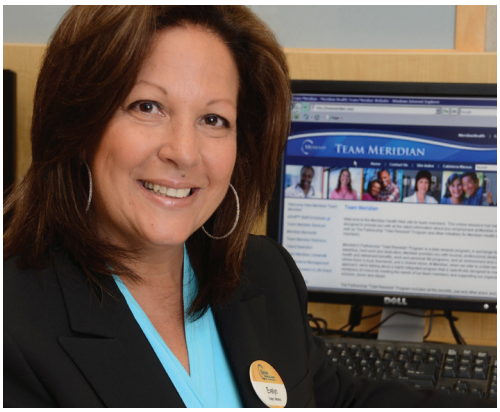
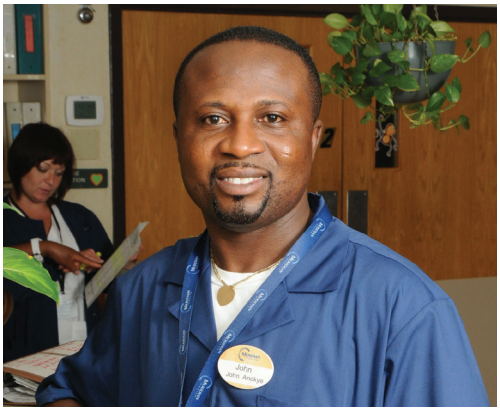
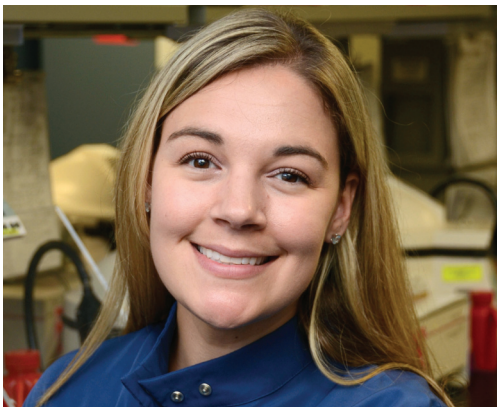
GROUP DENTAL INSURANCE









Healthplex Dental (International Healthcare Services, Inc.)

A Partnership "TOTAL REWARDS" Program

SUMMARY PLAN DESCRIPTION OF THE MERIDIAN HEALTH INTERNATIONAL HEALTHCARE SERVICES, INC. DENTAL PLAN

Effective January 1, 2014

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INTRODUCTION

This document provides the terms and conditions for eligibility and benefits under the **Meridian Health Dental Plan underwritten by International Healthcare Services, Inc. and administered by Healthplex, Inc.** ("Plan"). It is intended to be a comprehensive description of the participation requirements and available benefits under the Plan. Please keep it for your reference. When it states "Plan" or "Summary Plan Description" (or SPD), it is referring to this document. The Plan is a component plan under the Welfare Benefits Plan of Meridian Health (the "Welfare Benefit Plan"), which governs in the case of any difference between it and this document. If you would like to review the official Welfare Benefit Plan document, or to obtain a copy of any Plan document, please contact the Meridian HR Support Services Team.

This document outlines the dental benefits provided by the Contract. The benefits described in this document are subject to the provisions, terms, exclusions and conditions of the Contract. If there is a conflict between the Contract and this document, the provisions of the Contract will control. Benefits under the Plan are paid solely under and in accordance with the terms of the Contract.

Coverage under the Plan will take effect for an eligible Team Member and designated Dependents when the Team Member and such Dependents satisfy the Waiting Period and all the eligibility, enrollment and other requirements of the Plan.

While Meridian Health ("Employer") expects to continue the benefits described in this document, it reserves the right to terminate, suspend, discontinue or amend one or more of the benefits or other terms and conditions (including eligibility rules, cost sharing, benefit exclusions, and others) at any time and for any reason as described in *Amending and Terminating the Plan* below.

The Plan will pay benefits only for eligible expenses incurred during the time the Plan Participant or Dependent is covered by this Plan. No benefits are payable for expenses incurred before coverage began or after coverage terminated. For the purposes of this Plan, an expense for a service or supply is incurred on the date the service or supply is furnished.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility Requirements for Team Member Coverage. A person is eligible for Team Member coverage if he or she meets the following requirements:

☒ is a FullTime or Part-Time, Active Team Member of the Employer;

☒ completes the Team Member Waiting Period which ends on the first day of the calendar month following the date of hire or, if later, initial eligibility.

Team Members become eligible for coverage on:

☒ The effective date of the Plan, if you were employed on that date; or

☒ Completion of the Team Member Waiting Period (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;
- Meridian Health Resources doctors 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.

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; 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.

For purposes of eligibility for coverage, Full-Time and Part-Time Team Members who are absent because of health conditions are treated as if they are actively at work, and leaves of absence that qualify under the Family and Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA") are treated as periods of active employment to the extent such treatment is required and applicable to the Employer under such

laws. Notwithstanding the foregoing, a newly hired or newly eligible Team Member must report to work for the Employer in order for any coverage under the Plan to become effective.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

☒☒☒☒**Legal Spouse**. The term "*Spouse*" shall mean the person lawfully married to a Team Member under the laws of any domestic or foreign jurisdiction where such individual and Eligible Employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

☒☒☒☒**Civil Union Partner**. A same-sex Civil Union Partner under a Civil Union (see *Definitions* Section). The Plan Administrator may require documentation proving a legal Civil Union.

☒☒☒☒**Domestic Partner**. A Domestic Partner (see *Definitions* Section) who (a) is in a Domestic Partnership with a Team Member entered into prior to January 1, 2014, (b) was enrolled in the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan") as of January 1, 2014, and (c) has provided the applicable proof requirements, is eligible for coverage under the Plan. It is required that you provide an Affidavit of Domestic Partnership and documents evidencing joint responsibility. The following documentation for coverage for a domestic partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Team Member's will; durable power of attorney for healthcare or financial management; joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party.

A failure to elect to continue coverage under the Welfare Benefit Plan for your Domestic Partner during annual open enrollment for each Plan Year occurring on or after January 1, 2014, will result in a permanent loss of coverage under the Plan for your Domestic Partner, unless he or she thereafter becomes your Civil Union Partner or Spouse.

☒☒☒☒**Child(ren)**. Unmarried child(ren) from age 2 to age 19, or 23 if attending an accredited school, college or university on a full-time basis, will be eligible for coverage under the Plan. The term "children" or "child" shall include your natural children, adopted children, step-children, foster children, children placed with you in anticipation of adoption or becoming your foster child, child for whom you are the court-appointed legal guardian, or Domestic Partner's or Civil Union Partner's children. The phrase "child placed with you in anticipation of adoption" refers to a child who is lawfully placed with you for legal adoption by you.

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

☒☒☒☒**Legal Guardianship**. If you apply to enroll a child for whom you have a court-appointed legal guardianship within 30 days of the date legal guardianship is granted, coverage for the child becomes effective the date the legal guardianship is granted. A child for whom you acquire legal guardianship, but whom you do not apply to enroll until more than 30 days after the date legal guardianship is granted, will not be eligible until the next Annual Enrollment Period.

☒☒☒☒**Disabled Child**. A covered Dependent child who reaches the limiting age and is unmarried, Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, and primarily dependent upon the covered Team Member for support and maintenance; provided that the child became so incapacitated prior to reaching the limiting age and was enrolled in the Plan at that time. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, Meridian Health may require subsequent proof not more than once each year. Meridian Health reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Those dependents in military service are not eligible.

Special Note Regarding Tax Considerations
If you enroll an eligible dependent for dental coverage under the Plan, please keep in mind that if the dependent is not an IRS tax dependent for purposes of the Plan, the value of Meridian-provided dental coverage for the dependent will be treated as taxable income to you, a concept known as “imputed income.” In addition, if an eligible dependent is not an IRS tax dependent for purposes of the Plan, you will not be able to pay for your share of his or her dental coverage premium on a pre-tax basis under the terms of the Meridian Health Cafeteria Program. See the Section *Tax Treatment of Dependent Dental Coverage* below.

ELIGIBILITY LIMITATIONS

If a person covered under this Plan changes status from Team Member to Dependent or Dependent to Team Member, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to Plan maximums.

If both parents are Team Members, their children will be covered as Dependents of one parent, but not on both.

Eligibility Requirements for Dependent Coverage. A family member of a Team Member will become eligible for Dependent coverage on the first day that the Team Member is eligible for Team Member coverage and the family member satisfies the requirements for Dependent coverage. Plan coverage is not automatic. The Team Member has to timely enroll an eligible Dependent in order for the Dependent to be covered.

At any time, the Plan may require proof that a Spouse, Civil Union Partner, Domestic Partner, or child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan

Meridian Health shares the cost of Team Member and Dependent coverage under this Plan with the covered Team Members. Covered Active Team Members contribute their portion of the cost through pre-tax payroll deductions (subject to Plan terms and federal law requirements for pre-tax treatment of contributions), and **Meridian Health** bears the remaining cost of coverage from its general assets.

The **online** enrollment application for coverage details the required Team Member contributions to be deducted from payroll. Rates may change from time to time. Meridian Health will notify you of changes in the cost of coverage before you enroll for the next year. When an Active Team Member completes the **online** benefit enrollment process and elects to participate in this Plan, the Team Member is providing payroll deduction authorization.

TAXATION

Tax Treatment of Dependent Dental Coverage

Typically, the value of a dependent's coverage under an employer-sponsored group dental plan, such as the Plan, is not included in the employee's income for tax purposes. However, if a dependent does not meet very specific requirements specified in the federal tax code, then the dependent's dental coverage is taxable to the employee.

A dependent's Plan coverage will not result in imputed income if that dependent is your Spouse or IRS tax dependent for dental coverage purposes. For purposes of the Plan, a tax dependent for dental coverage includes a child who has not attained the age of 27 as of the end of the taxable year.

For these purposes, your child is an individual who is:

- your son, daughter (your son or daughter includes your natural or legally adopted son or daughter or an individual who is lawfully placed with you for legal adoption),
- stepson, or stepdaughter, or
- your eligible foster child (that is, an individual who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

If an individual does not meet the above definition of child, he or she will still be your tax dependent for dental coverage purposes if he or she is a U.S. citizen or resident who is either a Qualifying Child or a Qualifying Relative, as described below.

A Qualifying Child is a person who:

- is your child, grandchild, brother, sister, stepbrother, stepsister, or niece or nephew;
- is under the age of 19 (or 24 in the case of a student), or is any age and is permanently and totally disabled;
- does not provide over one-half of his or her own support for the calendar year;
- lives with you for over one-half of the calendar year; and
- is unmarried (that is, has not filed a joint tax return during the calendar year at issue).

If a person does not meet the definition of a Qualifying Child, he or she could be your tax dependent for purposes of the Plan by meeting the requirements to be a Qualifying Relative. A Qualifying Relative generally is a person who:

- receives over one-half of his or her support from you for the calendar year;
- is either related to you, or lives with you for the entire calendar year as a member of your household; and
- is not your Qualifying Child or any other taxpayer's Qualifying Child during the calendar year.

For example, your Civil Union Partner or Domestic Partner will be your IRS tax dependent for dental coverage purposes if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you, and lives with you for the entire calendar year as a member of your household. Even though a Civil Union Partner or Domestic Partner is not a "relative" in the traditional sense, he or she may meet the definition of a Qualifying Relative and could thereby be your tax dependent for Plan purposes.

Your Civil Union Partner's or Domestic Partner's child typically will not be your IRS tax dependent for Plan purposes unless your Civil Union Partner or Domestic Partner is also your IRS tax dependent for Plan purposes.

Meridian will calculate the value of Plan benefits related to your Civil Union Partner or Domestic Partner and his or her children, and any child for whom you are legal guardian, and add that to your regular pay as imputed income and you will pay your share of Plan coverage for your Civil Union Partner or Domestic Partner and his or her children, and any child for whom you are legal guardian, through after-tax payroll deductions, unless you complete and return a certification of federal tax dependent status, indicating that such individual qualifies as your federal tax dependent for dental coverage purposes.

ENROLLMENT

Enrollment Requirements. A Team Member must enroll for coverage by completing an enrollment application including the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Team Member is required to timely enroll for Dependent coverage also.

TIMELY OR LATE ENROLLMENT

☒☒☒☒**Timely Enrollment** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person initially becomes eligible for the coverage.

If two Team Members (e.g., husband and wife) are covered under the Plan and the Team Member who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Team Member with no waiting period as long as coverage has been continuous.

☒☒☒☒**Late Enrollment** An enrollment is "late" if it is not made on a "timely basis." Late Enrollees and their Dependents (if any) may enroll only during the next available Open Enrollment Period or if an applicable mid-year change event occurs and the employee elects coverage in a timely fashion as described in the Section *Change Events*.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

EFFECTIVE DATE

Effective Date of Team Member Coverage. A newly hired eligible Team Member will be covered under this Plan as of the first day of the calendar month following his or her date of hire or, if later, initial eligibility, provided that the Team Member satisfies the enrollment requirements described above.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the eligibility requirements are met; the Team Member is covered under the Plan; and all enrollment requirements are met.

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 enrollment period. Outside

of the annual 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 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 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.

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

TERMINATION OF COVERAGE

When a Team Member's Coverage Terminates. Except as otherwise described in the Section entitled *Continuation Coverage Rights under COBRA*, Team Member coverage will terminate on the earliest of these dates:

☒☒☒☒Termination of Active employment or change in employment status, resulting in loss of eligibility (that is, you cease to be an eligible Team Member). Terminations occurring between the 1st of the month and 15th of the month will end coverage as of the 15th. Terminations occurring after the 15th of the month will end coverage as of the last day of the month.

☒☒☒☒The last day of the calendar month for which any required Team Member contribution has been paid if the charge for the next period is not paid when due.

☒☒☒☒Upon a finding, by the Plan Administrator, that the Team Member attempted to defraud the Plan or intentionally misrepresented material fact to the Plan. Termination of coverage in such circumstances may take effect on a retroactive basis (i.e., rescission).

☒☒☒☒The date you effectively elect to cancel your coverage;

☒☒☒☒The date the Plan is amended, resulting in your loss of eligibility;

☒☒☒☒The date the Plan or Contract is terminated; or

☒☒☒☒The date you die.

When Dependent Coverage Terminates. Except as described in the Section *Continuation Coverage Rights under COBRA,* a Dependent's coverage will terminate on the earliest of these dates:

☒☒☒☒The date that the Team Member's coverage under the Plan terminates for any reason with the exception of death. Dependent coverage ends on the last day of the calendar month next following the month of the Team Member's death;

☒☒☒☒The last day of the calendar month a covered Spouse, Civil Union Partner, or Domestic Partner ceases to be a Dependent as defined under this Plan;

☒☒☒☒The last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan or reaches the limiting age (subject to any extension for a disabled Dependent child as described above), whichever comes first;

☒☒☒☒The last day of the calendar month for which any required Team Member contribution for the Dependent's coverage has been paid if the Team Member contribution for the next period is not paid when due;

☒☒☒☒Upon a finding, by the Plan Administrator, that the Dependent (or purported Dependent) attempted to defraud the Plan or intentionally misrepresented material fact to the Plan. Termination of coverage in such circumstances may take effect on a retroactive basis (i.e., rescission);

☒☒☒☒The date you effectively elect to cancel your Dependent's Plan coverage;

☒☒☒☒The date the Plan or Contact is terminated;

☒☒☒☒The date the Plan is amended, resulting in your Dependent's loss of eligibility; or

☒☒☒☒In the case of a Dependent enrolled pursuant to a QMCSO, the date as of which the Plan Administrator receives written evidence that the QMCSO is no longer in effect or that the dependent is enrolled in comparable health coverage.

CONTINUATION OF COVERAGE

In addition to COBRA continuation coverage (discussed later in this Plan in the section entitled *Continuation Coverage Rights under COBRA*), coverage may be continued in the following circumstances:

Continuation during Periods of Employer-Certified Disability or Leave of Absence. Individuals who would otherwise lose coverage under the Plan as a result of losing Team Member status (for example, as a result of disability, leave of absence, layoff, etc.) may, to the extent permitted under the Employer's employment policies and procedures, temporarily continue Plan coverage in accordance with such policies and procedures; provided, however, that such coverage continuation is subject to other terms and conditions under the Plan (including timely payment of required contributions) and any subsequent changes to Plan terms and conditions.

Continuation during Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave that is a qualifying leave under the federal Family and Medical Leave Act ("FMLA") (if applicable), Plan coverage will remain available to the extent required by FMLA.

To the extent Plan coverage terminates during the FMLA leave due to nonpayment of required contributions, coverage will resume as and to the extent required under FMLA (as applicable). Waiting periods will not apply for purposes of resuming coverage under the Plan, but all accumulated maximums (if any, such as visit limits, overall annual limit) will be reinstated.

Rehiring a Terminated Team Member. A terminated Team Member who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, with the exception of a Team Member returning to work directly from COBRA coverage, who then will have no break in coverage. Notwithstanding the foregoing, if a terminated Team Member is

rehired within 30 days and in the same calendar year, coverage as previously elected will be automatically reinstated upon reporting to work and the Team Member will not be able to make changes to your election.

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 HR Support Services Team.

OPEN ENROLLMENT

During the annual Open Enrollment Period, covered Team Members and their covered Dependents will be able to change their current benefit elections based on which benefits and coverage levels are right for them. In addition, Team Members and their Dependents who are Late Enrollees will also be able to enroll in the Plan during this period.

Benefit choices made during the Open Enrollment Period will become effective the following January 1st and remain in effect through December 31st of the same calendar year unless earlier terminated or modified under terms of this Plan (See the Section *Change Events*). To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one plan coverage option to another plan coverage option.

A covered Team Member who fails to make an election during Open Enrollment Period will automatically retain his or her current coverage election under the Plan or comparable coverage if coverage option is eliminated.

Team Members will receive detailed information regarding Open Enrollment Period from their Employer.

YOUR BENEFITS

Verification of Eligibility 1-800-468-0600

You should call the above number to verify eligibility for Plan benefits **before** the charge is incurred.

WHAT ARE THE BENEFITS?

All benefits described in this Schedule are subject to the exclusions and limitations described in this Summary Plan Description and the Contract. The meanings of these capitalized terms are in the *Definitions* Section of this document.

Participating Providers

This Plan has entered into an agreement with certain dentists, which in this Summary Plan Description are called Participating Providers. Any dental services which were not rendered, prescribed, arranged, or approved by a Participating Provider, except in cases of out-of-area dental emergency, are not covered by the Plan. In addition, a service not furnished by a Participating Provider, unless the service is performed by a licensed dental hygienist under the supervision of a Participating Provider or for an x-ray ordered by a Participating Provider, is not covered by the Plan.

HOW TO IDENTIFY PARTICIPATING PROVIDERS:

All **Meridian Health** members can access the **Meridian Health Participating Provider Directory** at the **www.teammeridian.com.**

You can find a listing of the Plan's Participating Providers and provider information by calling the Healthplex, Inc. hotline at 1-800-468-0600.

SCHEDULE OF BENEFITS

SERVICE OR SUPPLY	PATIENT COST
Diagnostic	
Charting history, oral examinations, periodic recall examination (every 6 months), emergency treatment	No Charge
Radiographic	
Complete intraoral series, periapical and bitewing films	No Charge
Intraoral periapical	No Charge
Each additional single film (periapical or bitewing)	No Charge
Occlusal view x-ray	No Charge
Lateral jaw x-ray each	No Charge
Four Bitewing x-ray films	No Charge
Antero-posterior x-ray of head and jaw	No Charge
Cephalometric radiograph	No Charge
Panoramic (panography) including bitewings, once every 3 years	No Charge
Preventive	
Oral prophylaxis (every 6 months)	No Charge
Topical Fluoride following prophylaxis	No Charge
Space maintainers - unilateral	No Charge
Space maintainers - bilateral	No Charge
Sealants (per tooth to age 14)	$15.00
Restorative Services	
Silver amalgam - 1 surface	No Charge
Silver amalgam - 2 surfaces	No Charge
Silver amalgam - 3 surfaces or more	No Charge
Silver amalgam reinforcement pins - 1st	No Charge
Each additional pin	No Charge
Composite filling, 1 surface	No Charge
Composite filling, 2 surfaces	No Charge
Composite filling, 3 surfaces	No Charge
Core Build-up (including any pins)	No Charge
Periodontia	
Root scaling and root planing (per quadrant)	No Charge
Prophylaxis, medication and minor bite correction	No Charge
Gingivectomy, Gingivoplasty, (per quadrant)	No Charge
Occlusal adjustment (and/or equilibration)	No Charge
Bite guards	No Charge

SERVICE OR SUPPLY	PATIENT COST
Osseous surgery, (per quadrant)	$75.00
Endodontics (including radiographs)	
Anterior root canal filling	No Charge
Bicuspid root canal filling	No Charge
Molar root canal filling	No Charge
Apicoectomy (per root)	No Charge
Simple Extractions (including LOCAL anesthesia)	
Single tooth	No Charge
Each additional tooth	No Charge
Oral Surgery Extractions (including LOCAL anesthesia)	
Surgical extraction	No Charge
Extraction of tooth (soft tissue impaction)	No Charge
Extraction of tooth (partial bony impaction)	No Charge
Extraction of tooth (complete bony impaction)	No Charge
Alveoplasty/Alveolectomy (per jaw maximum) per quadrant in conjunction with extraction	No Charge
Alveoplasty, including ridge extension, arch	No Charge
Excision of benign tumor, lesion diameter up to 2.5 cm.	No Charge
Removal of cyst up to 2.5 cm diameter	No Charge
Prosthetics (including adjustments and relines for 6 months following installation) removable	
Full upper denture	No Charge
Full lower denture	No Charge
Partial upper or lower denture without clasps, acrylic base	No Charge
Partial upper or lower denture with two chrome clasps with rests, acrylic base	No Charge
Partial upper or lower with chrome lingual or palatal bar with two clasps and rests, acrylic base	No Charge
Repair broken full or partial denture, no teeth damaged	No Charge
Repair broken full or partial denture, replace broken tooth	No Charge
Each additional tooth	No Charge
Replace broken tooth on denture, no other repairs	No Charge
Each additional tooth	No Charge
Adding tooth to partial denture to replace extracted tooth	No Charge
Each additional tooth	No Charge
Reattaching clasp on denture, clasp intact	No Charge
Replacing broken clasp with new clasp on denture	No Charge
Relining upper or lower full or partial denture (office) once every 3 years	No Charge
Relining upper or lower full or partial denture (lab) once every 3 years	No Charge
Jump case, complete denture (duplicate of denture) once every 3 years	No Charge
Crowns	
Post and Core	No Charge

SERVICE OR SUPPLY	PATIENT COST
Acrylic Crown	No Charge
Acrylic with Metal Crown (semi-precious)	No Charge
Porcelain Crown	No Charge
Two surface gold inlay	No Charge
Three or more surfaces gold inlay	No Charge
Porcelain fused to Metal Crown (semi-precious)	No Charge
3/4 cast Crown	No Charge
Full cast Crown	No Charge
Bridges, Abutments & Pontics (fixed)*	
Cast Bridge Crown or Pontic	No Charge
Maryland Bridge	No Charge
Porcelain fused to Metal Bridge Crown or Pontic (semi-precious)	No Charge
Plastic processed to Metal Bridge Crown or Pontic (semi-precious)	No Charge

***Refer to exclusion # 6**

Orthodontic Benefits. Orthodontics is that branch of dentistry which deals with the correction of a "bad bite." Causes vary from the size of the jaw to thumb sucking. Active treatment begins with x-rays and often extraction, if necessary. To correct the faulty occlusion (bite) teeth may then have to be moved with the aid of various orthodontic appliances such as bands and braces. Orthodontic benefits include: diagnosis, including models, photographs and cephalograms, active treatment, and retention treatment.

Orthodontics must be preauthorized by IHS or benefits will not be paid. Your Provider will seek preauthorization from IHS.

Active treatment will be rendered only for functional problems:

a) one cusp deviation in the occlusion of the maxillary and mandibular arches;
b) overbite - 4 mm or greater;
c) crossbites;
d) overjets - 4 mm or greater; and
e) crowding in excess of 4 mm.

Maximum, 24 months (to age 19)	$500.00 every 24 months
Adult (19 years or older)	$1,250.00 every 24 months

The benefits as outlined in the above Schedule of Benefits are subject to the following limitations:

Oral exams, bitewing x-rays, prophylaxes, scalings, and fluoride treatments	once every 6 months
Full mouth and panoramic x-rays	once every 36 months
Crowns, bridges, dentures and periodontal surgery	once every 60 months
Orthodontic treatment of Class II and Class III malocclusions	one 24 month case

In the event that there are alternative methods of treating a condition (e.g. varying techniques, substances and appliances) which methods carry different fees, any other provisions of the Plan notwithstanding, the Plan shall cover the service with the lesser fee, unless a method carrying the

greater fee is the only adequate treatment. In the event the Covered Person elects treatment beyond that determined to be adequate by the Plan, he shall remain responsible for that portion of the fee not covered by the Plan.

In the event that a Covered Person transfers from the care of one Provider to that of another Provider during a course of treatment, or if more than one Provider renders services for the same dental procedure, the Plan shall not be liable for more than the amount it would have been liable for had but one Provider rendered all the services during each course of treatment, nor shall the Plan be liable for duplication of services rendered.

DENTAL BENEFITS
WHAT'S COVERED

☒☒☒BASIC BENEFITS:

☒☒☒Diagnostic: Provides the necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment. These services include: oral examination and diagnostic services (including necessary dental x-rays and diagnostic tests). Examination will be provided only once in a 6-month period. Complete mouth radiograph series will be provided only once in a 3-year period, unless special need is shown. Supplementary bitewing radiographs are provided upon request, but no more than once every 6 months.

☒☒☒Palliative: Emergency treatment of dental pain. Palliative treatment is not covered when rendered on the same day as other treatment.

☒☒☒Preventive: Oral Prophylaxis. Topical application of fluoride. Space maintainers except when used as an activating device. Prophylaxis will be provided only once in any 6-month period. Topical application of fluoride will be provided to Covered Persons prior to attaining the age of 19.

☒☒☒Restorative: Restorations consisting of silver amalgam, acrylic, plastic or silicate cement, (or other material determined by the Claims Administrator at its sole discretion). Crowns, inlays and onlays are covered benefits only when teeth cannot be restored with any of the above materials. Benefits are allowed for one restoration per tooth, regardless of the number of restoration combinations actually placed. Replacement of crowns, inlays and onlays will be made only after 5 years have elapsed following any prior provision under an IHS program or any other dental program.

☒☒☒Oral Surgery: Extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures, and surgical and adjunctive treatment for minor pathological conditions. Local anesthesia when administered by a dentist in conjunction with oral surgery performed by a dentist.

☒☒☒Periodontics: Necessary procedure for treatment of the tissue supporting the teeth. Periodontal surgery (or treatment by a specialist) will only be covered by the Plan when the following conditions apply:

☒☒☒ A complete periodontal examination, diagnosis and treatment plan has been submitted.

☒☒☒ The patient has been instructed in proper oral hygiene techniques.

☒☒☒ The patient has demonstrated a desire and the ability to maintain a plaque-free dentition. Advanced perio treatment will be covered when it is in the best long-term interest of the patient, and is part of a total restorative treatment plan. Any copayments for perio surgery shall be as outlined in this Plan, and will apply per Plan Year.

☒☒☒Endodontics: Necessary procedures for pulpal and root canal therapy.

☒☒☒Emergency Care: Necessary palliative treatment or other emergency care under services covered herein.

☒☒☒PROSTHODONTIC BENEFITS:

☒☒☒Dental Prosthesis is to be provided where masticatory function is impaired and/or teeth missing. Full or partial dentures should be constructed when deemed necessary to replace missing teeth (not including third molars). The adjustment or repair of existing prosthetic appliances is included.

☒☒☒Fixed bridgework will only be a covered benefit when the use of a removable prosthetic device is unsatisfactory.

☒☒☒Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances satisfactory will be provided in accordance with the Plan. Prosthodontic appliances including abutment crowns will be replaced only after 5 years have elapsed following any prior provision of such appliances under the IHS program or any other dental program.

☒☒☒If, in the provision of prosthodontic services, the Covered Person, and the dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will cover the standard procedure and the Covered Person is responsible for all additional charges for customized services.

☒☒☒ORTHODONTIC BENEFITS:

☒☒☒Orthodontic Services for a correctable malocclusion, if prescribed in a Treatment Plan and consisting of the initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth shall be a covered benefit subject to the following provisions:

☒☒☒ Dependent children only to age 19 and adults over age 19 are eligible for benefits.

☒☒☒ Only those cases involving Class II or Class III malocclusions will be considered for coverage. Such cases must have either a unilateral crossbite, an overjet in excess of 4mm, or an overbite that impinges on the palatal gingiva.

☒☒☒ The Claims Administrator shall review the Covered Person's dental records, including the necessary radiographs, photographs, and models to determine whether orthodontic need and treatment are within the limitations and exclusions of this Plan prior to authorization of a Treatment Plan.

☒☒☒ For the purpose of determining benefits available for treatment in progress at the commencement or termination of a Covered Person's coverage hereunder, all orthodontic services shall be deemed to have been rendered on the date such services were performed.

☒☒☒ If the orthodontic services are terminated for any reason before completion of the orthodontic treatment approved by the Claims Administrator, the responsibility of the Plan shall cease with payment through the last such treatment.

☒☒☒ Any separate charges for the replacement and/or repair of any appliance furnished under the Treatment Plan shall not be eligible under the Contract.

☒☒☒ After the completion of orthodontic services as set forth in a Treatment Plan, further benefits for orthodontic services rendered to the same Covered Person shall not be provided.

PLAN EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THE PLAN.

☒☒☒Any dental services which were not rendered, prescribed, arranged, or approved by a Participating Provider except in cases of out-of-area dental emergency.

☒☒☒A service not furnished by a Participating Provider, unless the service is performed by a licensed dental hygienist under the supervision of a Participating Provider or for an x-ray ordered by a Participating Provider.

☒☒☒General anesthesia, analgesia and any service rendered in a hospital environment.

☒☒☒Any dental procedures which are undertaken primarily for cosmetic reasons, or dental care to treat accidental injuries, or congenital or developmental malformations.

☒☒☒Restorations, crowns or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive Treatment Plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.

☒☒☒Services which were started prior to the person becoming covered under this Plan.

☒☒☒Implants, precision attachments or other personalized restorations or specialized techniques.

☒☒☒Replacement of any existing crown, bridge or denture which can be made serviceable according to common dental standards.

☒☒☒Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of temporomandibular joint; stabilize periodontally involved teeth, restore occlusion, or restore tooth structure lost by attrition.

☒☒☒Treatment of unmanageable children or otherwise unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents of the patient.

☒☒☒Services not listed in the Schedule of Benefits are not covered.

☒☒☒Services rendered for injuries or conditions which are compensable under worker's compensation or employer's liability laws; services which are provided by any federal or

state or provincial government agency, or are provided without cost to the Covered Person, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable Covered Services.

☒☒☒Services rendered or items furnished for any condition, disease, ailment or injury occurring while the Covered Person is on active duty during military service, or for services or items provided under the laws of the United States of America or of any state of the United States or of any foreign country or of any political subdivision of any of the foregoing.

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

☒☒☒Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.

☒☒☒Procedures of an experimental nature.

☒☒☒Replacement of lost or stolen appliances or duplication to be used as a spare.

☒☒☒Any service or item which is determined by the Plan not to be a necessary service or item incidental to the condition, disease or injury for which the Covered Person is being treated.

☒☒☒Services or items to the extent covered under terms of a contract issued by another insurance, pre-paid dental benefit plan, major medical plan or policy.

☒☒☒Broken appointments.

☒☒☒Services, procedures, or appliances necessary to treat missing teeth, which teeth are already missing on the Effective Date, provided, however, that if a Covered Person is eligible for full dentures hereunder, such eligibility shall not be affected by the fact that any tooth or teeth were missing prior to the Effective Date.

☒☒☒Replacement of teeth by fixed bridgework where teeth are missing on both sides of the same arch or jaw. Where teeth are missing on both sides of the same arch, replacement of these missing teeth will be accomplished by removable prosthesis.

☒☒☒Expenses for occlusal equilibrations except to the extent necessary to treat periodontal disease.

☒☒☒Treatment of a patient/subscriber with a communicable disease without medical clearance from patient's physician.

☒☒☒Prosthetic devices, including but not limited to bridges, crowns, onlays, complete and partial removable dentures, for which the final impressions were taken while the individual was not covered under this agreement, or for which final impressions were taken while the individual was covered under this agreement, but are not finally installed or delivered to such individual within 60 days after termination of coverage.

☒☒☒Dental services which are obtained by a Covered Person in an office other than that in which he or she is enrolled and further, which services are not pre-authorized by the Plan. This exclusion does not apply to emergency dental services.

☒☒☒Treatment of fractures, dislocations, malignancies or neoplasms.

☒☒☒Posterior composites, except on the buccal surfaces of premolars.

☒☒☒Athletic mouthguards.

☒☒☒Prescription drugs, laboratory tests and/or examinations, premedications, or hospitalization charges.

☒☒☒Dental procedure required by reason of insurrection, invasion, bombardment, rebellion, revolution, military or usurped power or riot or resulting from any type of accidental injury, whether or not occurring by way of negligence, act of God, deliberate conduct of any kind or caused by anything other than naturally occurring biological factors, improper, poorly performed or non-existent dental hygiene or by reason of dental (including periodontal) disease.

DEFINITIONS

The words shown below have specific meanings when used in this Summary Plan Description. Please read these definitions carefully. They will help Members understand what services are provided.

ACTIVE TEAM MEMBER – A Team Member who is employed on the regular payroll of the Employer as an employee and who is scheduled to perform the duties of his or her job with the Employer on a full-time or part-time basis, at the Employer's place of business, or at another place to which a Team Member must travel to perform his or her regular duties.

CALENDAR YEAR - Each successive twelve-month period starting on January 1st and ending on December 31st.

CIVIL UNION – A same-sex civil 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. Meridian Health may require that the Team Member provide a Civil Union Certificate or Civil Union License.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONTRACT – The group dental contract by and between International Healthcare Services Inc. and Meridian Health, dated January 1, 1998, as amended.

COVERED PERSON – A Team Member or Dependent who is covered under this Plan.

COVERED SERVICES OR SUPPLIES - The types of services and supplies described in the "Schedule of Benefits" section of this Summary Plan Description. Read the entire Summary Plan Description to find out what benefits are limited or excluded.

DEPENDENT – Any individual who is related to the Team Member by being:

- a Spouse of the Team Member;
- a Civil Union Partner of the Team Member;
- a same-sex Domestic Partner of the Team Member who (i) entered into the Domestic Partnership with the Team Member prior to January 1, 2014 and (ii) has been continuously enrolled in the Welfare Benefit Plan since January 1, 2014; or
- a Dependent child of the Team Member.

Your "Dependent child" includes your natural child, adopted child, step-child, foster child, or Domestic Partner's or Civil Union Partner's child. The Plan treats a child as adopted or as a

foster child from the time the child is placed in the home of the Team Member for the purpose of adoption or of becoming a foster child. The term also includes an unmarried child for whom you are Legal Guardian. Please refer to the "Eligibility" section of this document.

A Dependent is not a person who is covered by the Plan as a Team Member.

At the Plan's discretion, the Plan can require proof that a person meets the definition of a Dependent.

DOMESTIC PARTNERS - An eligible Team Member and one other person who:

- have been living in a committed exclusive relationship of mutual caring and support for a period of at least twelve (12) months;
- intend for the Domestic Partnership to be permanent;
- are financially interdependent and jointly responsible for the common welfare and financial obligations of the household;
- is not legally or ceremonially married to any other individual, and, if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased;
- are mentally competent to enter into a contract according to the laws of the state in which they reside;
- are 18 years of age or older;
- are the same gender;
- do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside, if all other applicable marriage requirements of such state law were met;
- are not in the relationship solely for purposes of obtaining benefits; and
- if you live in a municipality or state that registers same sex domestic partners, you must be registered and provide the Plan Administrator with a copy of the registration.

Meridian Health requires that the Team Member submit an Affidavit of Same Sex Domestic Partnership, Civil Union Certificate or Civil Union License to be signed and dated by the Team Member certifying that a Domestic Partnership exists as defined within the Human Resources Policies and Procedures. Please refer to the Affidavit of Same Sex Domestic Partnership for additional information that may be required. Individuals who enter a domestic partnership with a Team Member on or after January 1, 2014 are not eligible under the Plan.

EFFECTIVE DATE - The date on which coverage begins for a Team Member.

EMPLOYER – Meridian or any Participating Employers.

ERISA – Employee Retirement Income Security Act of 1974, as amended.

FULL-TIME - A normal work week of at least **36** regularly scheduled hours.

IHS – International Healthcare Services, Inc., a wholly-owned subsidiary of Healthplex, Inc.

LATE ENROLLEE - An eligible Team Member or Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to first enroll under the Plan.

LEGAL GUARDIAN – A person recognized by a court of law as having the duty of taking care of a minor child as well as managing the property and rights of such minor.

NON-PARTICIPATING PROVIDER - Any licensed Provider other than a "Participating Dentist" or an "Out-of-Area Dentist."

OPEN ENROLLMENT PERIOD - The period of time, at least once annually, designated by an Employer during which Team Members enroll in the Plan and agree to make required payments, if any.

OUT-OF-AREA-DENTIST - A Provider who is fully licensed to practice dentistry at the time and place services under the Contract are rendered and is not participating in the Plan, or is practicing in an area not serviced by the Plan.

PART-TIME - A normal work week of at least **20** but less than **36** regularly scheduled hours.

PARTICIPATING EMPLOYER – The participating employers that have adopted the Plan with Meridian Health's approval and make the Plan available to their eligible Team Members are described in the Section *General Plan Information.*

PARTICIPATING PROVIDER - A Provider who is licensed to practice dentistry in the State of New Jersey pursuant to the Revised Statutes of New Jersey and who has agreed, in writing, with IHS to perform services eligible under the Contract and accept payments from IHS therefore on the basis provided in the Contract.

PLAN – Meridian Health International Healthcare Services, Inc. Dental Plan, which is a benefit plan for certain Team Members of Meridian Health and is described in this Summary Plan Description.

PLAN PARTICIPANT - Any Team Member or Dependent who is covered under this Plan.

PLAN SPONSOR – Meridian Health

PLAN YEAR – The 12 month period beginning January 1 and ending December 31.

PROVIDER - Any person fully licensed to practice dentistry at the time and place services eligible under the Contract are rendered.

SPOUSE – The person lawfully married to a Team Member under the laws of any domestic or foreign jurisdiction where such individual and Eligible Employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

TEAM MEMBER – 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 MEMBER ELIGIBILITY DATE -

☒☒☒the date of employment or, if later, initial eligibility; and
☒☒☒the day after any applicable waiting period ends.

TREATMENT PLAN – The written statement, on a form prescribed by the Claims Administrator, of diagnosis(es) or prognosis(es) and the course and types of care and treatment to be rendered by a Provider to a Covered Person together with associated charges, when such statement is signed by the Provider and Covered Person. A Treatment Plan may be approved for payment of benefits in whole or in part, by the Claims Administrator with determination as to approval at the discretion of the Claims Administrator and such determination is final.

WAITING PERIOD – The time between an Active Full-Time or Part-Time Team Member's first day of employment or, if later, initial eligibility, and first day of coverage under the Plan.

YOU, YOUR, AND YOURS – Refers to the Team Member.

CONFIDENTIALITY

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.

HOW TO SUBMIT A CLAIM

HOW TO FILE A CLAIM

Generally, you will not have to complete any claim forms for benefits under the Plan. Providers are generally responsible for submitting claims directly to Healthplex, Inc., the Claims Administrator. However, should you need to submit a claim, claim forms can be obtained by contacting the Claims Administrator.

Mail Claims to:
Healthplex, Inc. **333 Earle Ovington Blvd., Suite 300** **Uniondale, New York 11553-3608** **1-800-468-0600 (Uniondale)**

If you have a question about a claim, please call the Plan hotline at 1-800-468-0600. A representative will help you resolve your claim, including verifying that your claim is for a covered treatment.

CLAIMING YOUR BENEFITS (FILING A CLAIM)

When filing your claim, you must submit proof of each charge. It is extremely important that you secure copies of bills for all charges. All bills should be itemized.

Proof of claim must be furnished to the Claims Administrator within **180** days following the date services were provided. However, your claim will still be considered if it was not possible to furnish proof within that time and the proof was furnished as soon as reasonably possible, however, no later than **one year** from the original date services were provided.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim. Benefits will be payable to the Team Member unless payment has been assigned.

No action at law or in equity may be brought against the Plan prior to the expiration of **90** days after proof of loss has been furnished, nor shall such action be brought within one year from the expiration of the time within which proof of loss is required to be furnished.

The Plan shall have the right to examine any person whose loss is the basis for the claim as often as it may reasonably require. The Plan is not in lieu of and does not affect any requirements for workers' compensation insurance.

IF YOUR CLAIM IS DENIED

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.

Claim Notification Time-Frames

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:

- the Plan's receipt of the specified information; or
- 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 Denials 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.

ASSIGNING BENEFITS

You may authorize the Claims Administrator to make payments directly to Providers for Covered Services. However, the Claims Administrator reserves the right to make payments directly to you. Payments may also be made to an alternate recipient or that person's custodial parent or designated representative. Any payments made by the Claims Administrator fulfill all obligations of the Plan and/or the Plan Sponsor to pay for Covered Services.

You cannot assign your right to receive payment to anyone else without written consent of the Plan, except as may be required by a qualified medical child support order or any applicable state law. Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

APPEAL PROCEDURE

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 individual(s) 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.

If You Need Assistance

If you have any questions about the claims and appeals procedures, write or call the Claims Administrator at the numbers set forth in the Section *General Plan Information*.

EXHAUSTION REQUIREMENT

You may not bring a lawsuit to recover benefits under the Plan until you have exhausted the internal administrative process described above. Any participant or beneficiary can bring an action in connection with the Plan only in the District of New Jersey. No legal action may be commenced at all unless commenced no later than one year following the issuance of a final decision on the claim for benefits, or the expiration of the appeal decision period if no decision is issued. This one-year statute of limitations on suits for all benefits will apply in any forum where you may initiate such a suit.

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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Team Members and their families covered under the Plan will be entitled to the

opportunity to elect a temporary extension of dental coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This section is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is **Meridian Health**. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Team Members who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

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

☒☒☒ 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.

☒☒☒ 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.

☒☒☒ 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.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

☒☒☒ The death of a covered Team Member.

☒☒☒ The termination (other than by reason of the Team Member's gross misconduct), or reduction of hours, of a covered Team Member's employment.

☒☒☒ The divorce or legal separation of a covered Team Member from the Team Member's Spouse or the dissolution of the Team Member's Civil Union or Domestic Partnership.

☒☒☒ A covered Team Member becomes entitled to Medicare.

☒☒☒ A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

☒☒☒ A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Team Member retired at any time.

If the Qualifying Event causes the covered Team Member, or the covered Spouse, Civil Union Partner, or Domestic Partner or a Dependent child of the covered Team Member, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12-months before or after the date the bankruptcy

proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met.

Taking leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Team Member does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Team Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Team Member portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect 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.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Team Member and Spouse or dissolution of the Team Member's Civil Union or Domestic Partnership or a Dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee <u>in writing</u> within 60 days

after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any Spouse, Civil Union Partner, or Domestic Partner or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the Team Member*** covered under the Plan,
- the ***name(s) and address(es) of the Qualified Beneficiary(ies)***, and
- the ***Qualifying Event*** and the ***date*** it happened.

If the Qualifying Event is a ***divorce or legal separation or dissolution of a Civil Union or Domestic Partnership***, your notice must include ***a copy of the divorce decree, the legal separation agreement, or other appropriate documentation***. There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"**How does a Qualified Beneficiary become entitled to a disability extension?**"* That explanation describes other situations where notice from you or the Qualified Beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Team Members may elect COBRA continuation coverage for their Spouses, Civil Union Partners, or Domestic Partners and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If you or your Spouse, Civil Union Partner, or Domestic Partner or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the

loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Team Member.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - 29-months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the

Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18-months after the Qualifying Event, if there is not a disability extension and 29-months after the Qualifying Event, if there is a disability extension.

- In the case of a covered Team Member's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Team Member ends on the later of:

    - 36-months after the date the covered Team Member becomes enrolled in the Medicare program; or
    - 18-months (or 29-months, if there is a disability extension) after the date of the covered Team Member's termination of employment or reduction of hours of employment.

- In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36-months after the death of the retiree.

- In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Team Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

- In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36-months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed by a

second Qualifying Event that gives rise to a 36-month maximum coverage period within that 18- or 29-month period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Administrator.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not he/she is the covered Team Member) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Team Member's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Administrator.

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 YOUR 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.

GENERAL PROVISIONS

PLAN ADMINISTRATOR. The Board of Trustees of Meridian Health, or its delegate, is responsible for designating the person, committee, or entity that will serve as the Plan Administrator. Currently, the Plan Administrator is the Senior Vice President of Human Resources. The Plan Administrator is the named fiduciary of the Plan for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Administrator may allocate or delegate certain functions as it deems appropriate. The day-to-day operation of the Plan is managed by Healthplex, Inc., the Claims Administrator. The Claims Administrator has the discretionary authority to decide claims and appeals under the Plan.

Service of legal process may be made upon the Plan Administrator.

DUTIES AND AUTHORITY OF THE PLAN ADMINISTRATOR.

- ☒☒☒☒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.
- ☒☒☒☒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.
- ☒☒☒☒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 Plan Administrator, or its designee or delegate decides in its discretion that the applicant is entitled to them.
- ☒☒☒☒To describe procedures for filing a claim for benefits and to review claim denials.
- ☒☒☒☒To keep and maintain the Plan documents and all other records pertaining to the Plan.
- ☒☒☒☒To appoint a Claims Administrator to pay claims.
- ☒☒☒☒To perform all necessary reporting as required by ERISA.
- ☒☒☒☒To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

☒☒☒☒To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan Sponsor.

AMENDING AND TERMINATING THE PLAN. The Employer 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.

PLAN FUNDING AND PAYMENT OF BENEFITS. Plan benefits are paid from the general assets of the Employer and contributions made by the covered Team Members. The level of any Team Member contributions will be set by the Plan Administrator. Benefits are generally paid through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the Plan Administrator may deduct the amount of overpayment from future benefits payable.

STATEMENT OF ERISA RIGHTS

YOUR RIGHTS UNDER ERISA

As a participant in the Plan described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("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 Summary Plan Description. 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, your Spouse or 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 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 preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from the Plan or 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 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 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.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The benefits offered under the Plan are provided through an insurance contract with IHS. Benefits are administered and paid by IHS.

PLAN NAME
The Meridan Health International Healthcare Services, Inc. Dental Plan is a component plan 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

NAMED FIDUCIARY
Meridian Health
1350 Campus Parkway
Neptune, New Jersey 07753

AGENT FOR SERVICE OF LEGAL PROCESS
Meridian Health
Attn: General Counsel

1350 Campus Parkway
Neptune, New Jersey 07753

CLAIMS ADMINISTRATOR
Healthplex, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553-3608
1-800-468-0600 (Uniondale)

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.
22-3557994	Quality Care Management, LLC
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.
22-2620595	Meridian Quality Care, Inc.