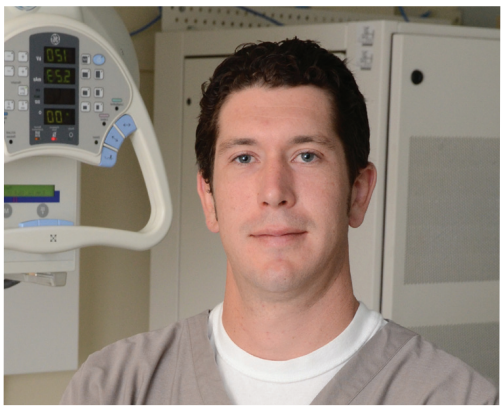

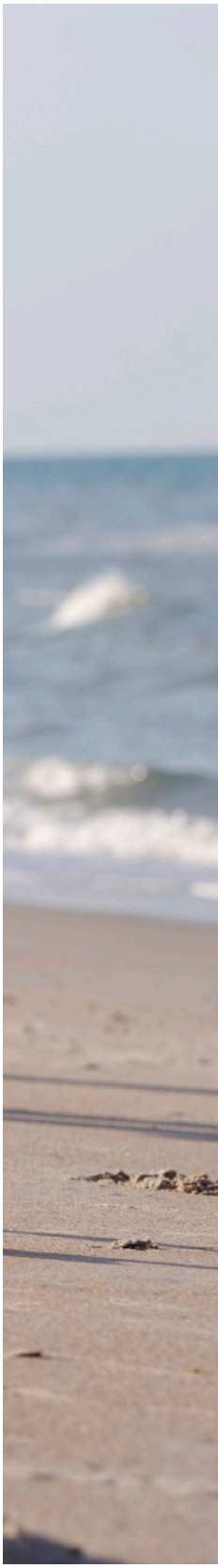

MERIDIAN HEALTH

Group Life and AD&D Insurance

A Partnership "TOTAL REWARDS" Program

MERIDIAN HEALTH

Class 3
Basic Life Insurance
Basic Accidental Death & Dismemberment Insurance
Supplemental Life Insurance
Dependent Life Insurance

The New Jersey Hospital Association Insurance Fund
760 Alexander Road - P.O. Box 1
Princeton, N.J. 08543-0001

TO MERIDIAN HEALTH TEAM MEMBERS:

All of us appreciate the protection and security insurance provides.

This Summary Plan Description describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to The New Jersey Hospital Association Insurance Fund.

TABLE OF CONTENTS

A SUMMARY

This is a very brief summary of the coverage and benefits available to you under the Group Policy.

The Policy sets forth the rights and obligations of both the Policyholder and Us.

Coverage is described in detail on the pages that follow including the losses and expenses we do not cover.

This Summary Plan Description describes your insurance provided under the Policy. It is important that you READ YOUR SUMMARY PLAN DESCRIPTION carefully.

SECTION 1

GROUP COVERAGE AT A GLANCE

PLAN EFFECTIVE DATE

COVERAGE AVAILABLE TO YOU

COVERAGE AVAILABLE TO YOUR DEPENDENTS

COST TO YOU

MINIMUM HOURS REQUIREMENT

WAITING PERIOD

REHIRE

CHANGES IN YOUR AMOUNTS AND MAXIMUM BENEFITS AVAILABLE TO YOU

INSURANCE AMOUNTS AND MAXIMUM BENEFITS AVAILABLE TO YOUR DEPENDENTS

REDUCTION SCHEDULE

This "coverage at a glance" section is a general overview. The Plan described in this booklet is provided by a Group Policy issued by Us to the Policyholder. The coverages, benefits and amounts described and all other provisions are subject to the Group Policy. They may be changed at a later date. Any change in your insurance, class or status will take effect only when all of the Policy terms have been met.

PLAN EFFECTIVE DATE

The Plan Effective Date is January 1, 2016

COVERAGE AVAILABLE TO YOU

Basic Life Insurance

Basic Accidental Death and Dismemberment Insurance

Supplemental Life Insurance

COVERAGE AVAILABLE TO YOUR DEPENDENTS

Supplemental Life Insurance

COST TO YOU

No contributions are required toward the cost of your Basic Life Insurance and Basic Accidental Death and Dismemberment (AD&D) Insurance.

Contributions are required toward the cost of your Supplemental Life Insurance and Dependent Life Insurance.

MINIMUM HOURS REQUIREMENT

Full-Time and Part-TimeTeam Members must be working at least 20 hours per week and be employed on the regular payroll of the Employer for that work.

WAITING PERIOD

You are eligible for benefits on the first of the month following date of hire or, if later, initial eligibility provided you meet the minimum hours requirement.

Amounts that require evidence of insurability will be effective on the first day of the month, which falls on or next after the date of approval.

REHIRE

If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply towards the waiting period. All other Summary of Benefits' provisions apply.

CHANGES IN YOUR INSURANCE

Any increase in your insurance amounts or coverage as a result of an increase in your salary will take effect on the latest of these dates:

- The first day of the month which falls on or next after the date we approve your proof of good health, if such proof is required by then current underwriting standards

- The first pay period after a salary increase becomes effective

- The first day of the month, which falls on or next after the date you come back to active, full-time or part-time work if you are not at active, full-time or part-time work on the date the increase would take effect

- In no event will any increase in your insurance amounts or coverage take effect on the date shown above unless you pay your first contribution towards the cost within 31 days after that date

Any decrease in your insurance amounts or coverage as a result of a decrease in your salary will take effect on the first pay period after a salary decrease becomes effective.

Except for a change in your insurance amounts or coverage as a result of a corresponding change in your salary, you may change your coverage elections for supplemental life insurance only during annual enrollment. Elections made during annual enrollment are effective on the latest of the following dates:

- January 1 of the following year

- The first day of the month which falls on or next after the date we approve your proof of good health, if such proof is required by then current underwriting standards

- The first day of the month, which falls on or next after the date you come back to active, full-time or part-time work, if you are not at active, full-time or part-time work on the date the change would take effect.

INSURANCE AMOUNTS AND MAXIMUM BENEFITS AVAILABLE TO YOU

CLASS 3: All full-time and part-time active team members who meet the minimum hour requirement described above and are not included in Class 1, 2 or 5.

Basic Life Insurance Amount	One times your basic annual earnings, rounded to the next higher multiple of $1,000 up to a maximum of $1,000,000
Basic Accidental Death And Dismemberment Insurance Amount	An amount equal to your basic life benefits to a maximum of $1,000,000
Basic Life Guarantee Maximum	Amounts above $500,000 are subject to evidence of insurability
Supplemental Life Insurance Amount	One, two, three or four times your basic annual earnings, rounded to the next higher multiple of $1,000 up to a combined maximum of $1,000,000
Supplemental Life Guarantee Maximum	Combined supplemental and basic life amounts above $600,000 are subject to evidence of insurability

Coverage applied for more than 31 days from the initial eligibility date (including annual enrollment and benefit increases) is subject to evidence of insurability. You must be actively at work on the effective date of your coverage for this benefit to begin.

SUPPLEMENTAL LIFE INSURANCE AMOUNTS AND MAXIMUM BENEFITS AVAILABLE TO YOUR DEPENDENTS

Spouse/Civil Union Partner/Same Sex Domestic Partner Supplemental Amount	$10,000 or $20,000
Children from live birth to 19 years old (to age 23 if a full-time student)	$5,000 or $10,000
Spouse/Civil Union Partner/Same Sex Domestic Partner Supplemental Life Guarantee Maximum	$20,000 if applied for within 31 days of eligibility
Children Supplemental Life Guarantee Maximum	$10,000

REDUCTION SCHEDULE

The amount of your Life, AD&D, and Supplemental benefits will be reduced on the first of the month coincident with or next following your 70th and 75th birthdays as shown below:

Basic Life and AD&D:

- Benefit at age 70-74 – 1 times your BAE times 65%
- Benefit at age 75+ – 1 times your BAE times 40%

Example:		Salary	Benefit
	Age 70 – 74	$50,000	$50,000 x .65 = $ 32,500
	Age 75 +	$55,000	$55,000 x .40 = $ 22,000

Supplemental Life:

- Benefit at age 70-74 – 65% of the amount of insurance elected (1, 2, 3 or 4 times BAE)
- Benefit at age 75+ – 40% of the amount of insurance elected (1, 2, 3 or 4 times BAE)

Example: Benefit elected 2 times salary

	Salary	Benefit
Age 70 – 74	$50,000	$100,000 x .65 = $ 65,000
Age 75 +	$55,000	$110,000 x .40 = $ 44,000

SECTION 2

SOME TERMS YOU SHOULD KNOW

SOME TERMS YOU SHOULD KNOW

Accredited School means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

Active Employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under minimum hours requirement in each plan.

Your work site must be:

- Your Employer's usual place of business;
- An alternative work site at the direction of your Employer, including your home; or
- A location to which your job requires you to travel

Annual Enrollment Period means a period of time before the beginning of each plan year in which you have the opportunity to enroll or change benefit elections subject to medical evidence.

Basic Annual Earnings (BAE) means your basic yearly rate of pay from your Employer inclusive of shift differentials. This does not include overtime pay, bonuses, commissions or any other form of extra pay.

Benefit Plan means the kinds and amounts of coverage which you are eligible to be covered for under the policy in accordance with your employer's initial request for participation or as later may be amended. The plan and any amendments must be approved by Us.

Child(ren) of an insured team member must meet the following requirements:

(1) Your unmarried children from live birth to under age 19. The term child includes your natural child, adopted child, stepchild, foster child, child for whom you are legal guardian, child placed with you in anticipation of adoption or becoming your foster child. Same Sex Domestic Partner's or Civil Union Partner's child, and any other child who lives with you in a parent-child relationship and depends on you for his or her full support.

(2) Your unmarried children, age 19 or older, but under age 23, who are full-time students at an accredited school or college and fully supported by you. "Full-time student" means full-time as defined by the rules of the school or college.

Dependent means your Spouse/Same Sex Domestic Partner, or Civil Union Partner and/or Child(ren).

Civil Union Partner means a person who (a) has established and is in a Civil Union with an insured team member, (b) gives us Evidence of Insurability satisfactory to Us, if We ask for it (see Evidence of Insurability of this Policy Schedule), and (c) is able to perform the normal activities of a person of the same age and gender (a civil union partner who is disabled is NOT eligible). A Civil Union is 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. Meridian Health requires that the team member provide a Civil Union Certificate or Civil Union License.
Dependent means your Spouse/Civil Union Partner/Same Sex Domestic Partner and/or Child(ren).

Employer means your employer shown on the Summary Plan Description page of this booklet as the Participating Health System.

Evidence of Insurability means a statement that you or your dependent (excluding children) must provide as proof of good health.

Guarantee Issue Maximum is the amount of insurance for which you are automatically insured. For life amounts over the guarantee issue maximum an evidence of insurability form must be completed within 31 days of eligibility. Approval for amounts over the guarantee issue maximum is subject to the results of the application.

Insured means any person covered under a plan.

Late Entrant means enrolling in supplemental life insurance more than 31 days after the original effective date including during annual enrollment.

Layoff or Leave of Absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

The **Participating Health System** is Meridian Health.

The **Policyholder** is New Jersey Hospital Association Insurance Fund.

Same Sex Domestic Partner is a person who (a) is in a Same Sex Domestic Partnership with a team member that was 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, (c) has provided the applicable proof requirements, (d) gives us Evidence of Insurability satisfactory to Us, if We ask for it (see Evidence of Insurability of this Policy Schedule), , and (e) is able to perform the normal activities of a person of the same age and gender (a same sex domestic partner who is disabled is NOT eligible). It is required that you provide an Affidavit of Same Sex Domestic Partnership and documents evidencing joint responsibility. The following documentation for coverage for a same sex domestic partner is acceptable: joint mortgage or lease; designation of the Same Sex Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Same Sex 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 Same-Sex Domestic Partnership means an insured 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 living in a municipality or state that registers same sex domestic partners, have registered and provided Meridian Health with a copy of the registration.

Meridian Health requires that the team member submit an Affidavit of Same Sex Domestic Partnership to be signed and dated by the Team Member certifying that a Same Sex Domestic Partnership exists as defined within the Meridian Health's Human Resources Policies and Procedure.

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.

Spouse of an insured team member means the person who (a) is at least 16 years old and is lawfully married to a team member under the laws of any domestic or foreign jurisdiction where such individual and team member were married, (b) gives us Evidence of Insurability satisfactory to Us, if We ask for it (see Evidence of Insurability of this Policy Schedule), and (c) is able to perform the normal activities of a person of the same age and gender (a spouse who is disabled is NOT eligible). Meridian Health requires a certified copy of a marriage certificate.

A Spouse/Civil Union Partner/Same Sex Domestic Partner does not include anyone who is personally eligible as a team member under this Policy.

You and **Your** is the team member.

We, **Us** and **Our** mean the insurance company identified on the certification page of this booklet.

SECTION 3

HOW TO BECOME INSURED

WHO IS ELIGIBLE, AND WHEN

WHEN YOUR INSURANCE BEGINS

EVIDENCE OF INSURABILITY

HOW TO APPLY FOR SUPPLEMENTAL LIFE INSURANCE

WHO IS ELIGIBLE, AND WHEN

All active Team Members in Class 3 who meet the minimum hours requirement described above are eligible for coverage under the plan.

Notwithstanding the foregoing and except as noted, the following Team Members are not eligible for Basic Life Insurance, Basic Accidental Death and Dismemberment Insurance, or Supplemental Life Insurance under the plan:

- Part-time Team Members at Meridian Nursing & Rehabilitation Ocean Grove;
- Team Members at Shore Care Nursing;
- Team Members at Quality Care Management;
- Meridian Health Resources physicians;
- Part-time Team Members at Meridian Nursing & Rehabilitation Brick, except for certain grandfathered Team Members with coverage under prior eligibility;
- Part-time Team Members at Meridian Nursing & Rehabilitation Shrewsbury, except for (i) certain grandfathered Team Members with coverage under prior eligibility and (ii) Team Members covered by a collective bargaining agreement providing for coverage;
- Per diem Team Members;
- Part-Time Team Members at Bayshore Health Care Center Inc. and The Willows at Holmdell, except for (i) certain grandfathered Team Members and (ii) Team Members covered by a collective bargaining agreement providing for coverage; and
- Team Members covered by a collective bargaining agreement, unless the terms of the collective bargaining agreement provide for eligibility under the plan.

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- The plan effective date; or
- The day after you complete your waiting period.

Amounts that require evidence of insurability will be effective on the first day of the month, which falls on or next after the date of approval

WHEN YOUR INSURANCE BEGINS

Basic Life: Your insurance starts when you fulfill your eligibility period. If you are applying for amounts over the guarantee issue maximum, these amounts will be effective on the first of the month, following the date of approval.

Supplemental Life: Your insurance starts as outlined below if you have enrolled within 31 days of your original eligibility date. Benefits that have been applied for more than 31 days from the original eligibility date, during annual enrollment, or for increased amounts, will be effective once you have submitted evidence of insurability and we have approved your application. Subject to the Special Requirements below, your insurance will start on the latest of these dates.

1. Your eligibility date;
2. The first day of the month which falls on or next after the date you apply for this insurance;
3. The first day of the month, which falls on or next after the date we approve your proof that you are insurable by Our standards for this insurance.

Special Requirements

1. In no event will your insurance start on the date shown above unless you pay your first required contribution towards its cost within 31 days after that date;
2. You must be an eligible team member who is actively at work for your Employer in order for your insurance to start. If you are not actively at work, your insurance will start on the date you come back to active work.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for Life Insurance if:

- Life benefit is over the guarantee issue maximum
- You enroll as a late entrant for supplemental life insurance (more than 31 days from the original effective date)
- You enroll during annual enrollment
- Increases in current supplemental life benefits (i.e. opting for two times salary when you currently have one times salary)

An "Evidence of Insurability" form must be completed within 31 days of eligibility and supplied to the insurance company as proof of good health.

If the insurance amount you are applying for is not approved you will receive the greater of:

1. The benefit level you had prior to applying; or
2. The guarantee issue maximum (for first eligible only; late entrants must be approved for all amounts above current levels).

HOW TO APPLY FOR SUPPLEMENTAL LIFE INSURANCE

To apply, contact your Human Resources Department

When you apply for coverage over the guarantee issue maximum or as a late entrant, (if more than 31 days from your original effective date or during annual enrollment) or, for increases in your supplemental life insurance, you will be required to submit evidence of insurability.

Please note that you may modify your supplemental life insurance election only during annual enrollment, subject to the above requirements. Elections made during annual enrollment are effective on the latest of the following dates:

- January 1 of the following year
- The first day of the month which falls on or next after the date we approve your proof of good health, if such proof is required by then current underwriting standards
- The first day of the month, which falls on or next after the date you come back to active, full-time or part-time work, if you are not at active, full-time or part-time work on the date the change would take effect

SECTION 4

DEPENDENT LIFE INSURANCE

HOW TO APPLY FOR DEPENDENTS INSURANCE

WHO ARE ELIGIBLE DEPENDENTS

WHEN DEPENDENTS BECOME ELIGIBLE

WHEN DEPENDENT INSURANCE STARTS

CHANGES IN DEPENDENTS INSURANCE

DEPENDENT BENEFICIARY

HOW TO APPLY FOR DEPENDENTS INSURANCE

To apply, contact your Human Resources Department.

Dependents, who apply more than 31 days from their eligibility date, during annual enrollment (excluding child coverage) or for increased amounts, will need to provide evidence of insurability.

WHO ARE ELIGIBLE DEPENDENTS

Except as stated below, your dependents may become eligible under this Plan:

- A Spouse, Civil Union Partner, or Same Sex Domestic Partner (each as defined above) of an insured team member.
- Child(ren) (as defined above) of an insured team member.

No person who is eligible as a team member under this Plan may be eligible as a dependent. Also, a dependent person may not be a dependent of more than one team member.

Dependents on active military duty are not eligible

WHEN DEPENDENTS BECOME ELIGIBLE

A dependent becomes eligible on the latest of these dates (but not before the Plan Effective Date, or the date you are in a class eligible for dependents insurance):

- The date your insurance begins
- The date he or she becomes a dependent
- A newly adopted child, the date the child is placed with you pending final adoption. Such a child will remain eligible unless the adoption process stops, and the child is removed from placement with you.

WHEN DEPENDENTS INSURANCE STARTS

Coverage for a dependent will start on the latest of these dates:

- His or her eligibility date.
- The first day of the month, which falls on or next after the date you apply for dependents insurance.
- The date your own insurance, which provides similar coverage, starts.
- The first day of the month, which falls on or next after the date we approve any required proof that the dependent is insurable by Our standards for this insurance.
- If a Special Requirement shown below applies, the date that requirement is met.
- In the case of a dependent (other than a newborn child or newly adopted child) who is confined in a hospital or similar place, or at home in lieu of Hospitalization on the date his or her insurance would take effect, the first day of the month which falls on or next after the date of his or her final discharge.

Special Requirements

1. In no event will the dependent's insurance start on the date shown above unless you pay the first required contribution toward its cost within 31 days after that day.
2. This Special Requirement applies if you voluntarily terminate dependent coverage and again apply for dependents insurance. In this case, you must give Us acceptable proof that each dependent you have is insurable by Our standards before he or she may be insured again under this Plan. His or her insurance will start on the first day of the month, which falls on, or next after the date we approve that proof that he or she is insurable by Our standards. (You must provide this proof at your own expense).

CHANGES IN DEPENDENTS INSURANCE

You may modify your dependents life insurance election only during annual enrollment. Elections made during annual enrollment are effective on the latest of the following dates:

- January 1 of the following year
- The first day of the month which falls on or next after the date we approve your dependent's proof that he or she is insurable by Our standards, if such proof is required by then current underwriting standards;
- If your dependent is not approved for the increase in coverage, your dependent will remain at the same level your dependent had prior to applying for the increase.
- In the case of a dependent who is confined in a hospital or similar place, or at home in lieu of hospitalization on the date the increase would take effect, the first day of the month which falls on or next after the date of his or her final discharge from the facility or home care program.

In no event will any increase in a dependents insurance amounts or coverage take effect on the date shown above unless you pay your first required contribution toward its cost within 31 days after that date.

DEPENDENT BENEFICIARY
The team member is the beneficiary unless otherwise noted.

SECTION 5

LIFE INSURANCE PROVISIONS

THE BENEFIT

TEAM MEMBER BENEFICIARY

HOW WE PAY THE BENEFIT

LIMITS ON CONTESTING COVERAGE

ASSIGNMENTS

THE BENEFIT

If you die while insured under this coverage, we will pay your life insurance amount shown in Section 1. This amount will be paid to your beneficiary when we receive proof of your death.

TEAM MEMBER BENEFICIARY

Your beneficiary is the person or persons you name to receive your life insurance benefit.

You must name your beneficiary in writing on a form provided by your Human Resources Department. We will accept the beneficiary you named in writing under your employer's prior plan if coverage under that plan was in effect on the day prior to the effective date of this plan we will pay only the beneficiary shown on record.

You may change your beneficiary at any time by completing a change of beneficiary card and filing it with your employer. When the notice is received, the change will go into effect as of the date you signed the notice. Your notice will not affect any payment made, or other action taken, before it was received.

If you name more than one beneficiary, but do not state how much you want each to get, then each one who is living when you die will get an equal share.

You may also name an alternate beneficiary to receive the amount in case the first beneficiary dies before you do.

If no beneficiary has been named, or if no beneficiary survives you, a statement of heirs must be completed and the benefit will be paid to your estate. Once the benefit is paid, we have no further liability for the amount paid.

HOW WE PAY THE BENEFIT

The amount of insurance will be paid in one lump sum

LIMITS ON CONTESTING COVERAGE

We rely on statements you make regarding your insurability. We will not contest the validity of coverage based on these statements unless:

- The statements are in writing and signed by you; and
- A copy has been given to you or to your beneficiary

In any case, we will not contest your coverage after it has been in effect for two years.

ASSIGNMENTS

You may assign your life insurance and benefit under this Coverage. The assignment must be on a form acceptable to the insurance company.

We are not responsible for the validity of any assignment.

Our acceptance of an assignment does not make Us liable for any action or payment or other settlement We made before that acceptance.

SECTION 6

BENEFIT IF YOU BECOME TOTALLY DISABLED
(Applies to team member only)

BENEFIT IF YOU BECOME TOTALLY DISABLED

IF YOU DIE WHILE COVERED UNDER THIS BENEFIT

BENEFIT IF YOU BECOME TOTALLY DISABLED

Total disability or **totally disabled** means that either:

- You are not able to work at all at any job or business for pay or profit due to injury or sickness, and you are totally disabled for at least 6 months in a row; or
- You have been certified by a doctor as having a sickness or condition that can reasonably be expected to result in death within 24 months of the date of certification.

Once approved, this benefit will start on the date of total disability. It will continue while you stay totally disabled as long as you send proof of your continued total disability once each year.

This proof must be sent in during the 3 months before the anniversary of the date your first proof was sent in. We also have the right to ask that you be examined by one of Our own doctors, at Our expense.

Your amount of life insurance under this benefit is the amount for which you were insured on your last day of active, full-time or part-time work. If this amount would have been reduced when you reached a certain age, the reduction will apply. Also, this amount will be reduced by the amount of any benefit payable on account of your death under the **How to Convert to Individual Insurance Section**. And it will be reduced by any amount we have paid under the **Living Benefit Option**.

This benefit will end automatically on the date you:

- Are no longer totally disabled; or
- Fail to give Us proof of continued disability; or
- Refuse to be examined by a doctor of Our choice; or
- Reach age 70; or
- 12 months after your date of disability if you were disabled on or after age 60 but prior to age 70;

After this benefit ends, you have 31 days in which you may choose to convert to an individual policy other than term life insurance, just as if your employment had ended, if the Group Master Policy is in force at the time your rights under the Waiver of Premium provision ends. If you return to work during these 31 days, and become insured again under this coverage, you cannot then convert to individual insurance.

The **How to Convert to Individual Insurance Section** tells how you may convert to your own policy when your group life insurance ends. You cannot use this right to convert and have your group life insurance continued under this benefit at the same time. If you have converted to your own life policy that policy must be returned to Us without claim before any payment will be made under this benefit. We will refund the premiums you paid for that policy.

Part A

If you become totally disabled, your life insurance may be continued under this coverage without premium charge. This insurance will continue even if the policy or this coverage under the policy ends. To qualify, these conditions must be met:

- **Your total disability must start before you reach age 60**; and
- Your total disability must start while you are insured under this coverage and before your employment ends; and
- We must receive proof of your total disability within 12 months after the date you become totally disabled. If you die within 12 months after the date you become totally disabled but before proof is submitted, this proof must be received within 12 months after your death.

While your insurance is being continued, We have the right to ask that you be examined by one of Our own doctors.

This benefit terminates at age 70

Part B

If you are totally disabled on or after age 60 your life insurance may be continued for up to 12 months under this coverage without premium charge. This insurance will continue even if the policy or this coverage under the policy ends. To qualify, these conditions must be met:

- **Your total disability must start on or after the date you reach age 60 and before you reach age 70; and**
- Your total disability must start while you are insured under this coverage and before your employment ends; and
- We must receive proof of your total disability within 12 months after the date you become totally disabled. If you die within 12 months after the date you become totally disabled but before proof is submitted, this proof must be received within 12 months after your death.

While your insurance is being continued, We have the right to ask that you be examined by one of Our own doctors.

This benefit terminates at age 70

Part C

If you become disabled on or after age 70 you are not eligible for benefits under this coverage. Your life insurance coverage terminates on the first day of the month following your date of total disability. You have 31 days in which to convert your life insurance benefit.

All Policyholders: If this policy or coverage under this policy ends, you will be given the opportunity to convert to an individual policy other than term.

IF YOU DIE WHILE COVERED UNDER THIS BENEFIT

Before payment will be made under this benefit, We must also receive:

- Proof of your death; and
- Proof that you remained totally disabled until your death.

Even if We do not receive a proof within the time required, the claim will not be denied if the proof is received as soon as it is reasonably possible.

SECTION 7

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE COVERAGE

Applies to Basic Benefits only, does not apply to Supplemental Amounts for you or your dependent

WHAT IS ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE?

Under this coverage, We will pay the benefit shown below if these conditions are met:

- Your death or loss occurs within 365 days after an accidental bodily injury; and
- Your death or loss is the direct result of that injury and independent of all other causes; and
- The injury takes place while you are insured under this coverage.

The covered losses and percentages are shown below in the Table of Covered Losses. Upon receipt of proof that your loss occurred under the circumstances described above, the benefit will be paid to you, or to your beneficiary in the event of your death. The most that will be paid for all covered losses from any one accident is the full accidental death amount shown in Section 1. If, as a result of any one accident, you suffer more than one covered loss with respect to any one limb, payment will be made only for the covered loss for which the greatest percentage is payable.

TABLE OF COVERED LOSSES

Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
Either One Hand or One Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
One Arm or One Leg	75%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing in Both Ears	50%
Thumb and index finger of the same hand	25%
All four fingers on one hand	25%
All of the toes of one foot	12.5%

The maximum amount of accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

Loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finger mean severance through or above the metacarpophalangeal joints.

Quadriplegia means the total and permanent paralysis of both upper and lower limbs.

Loss resulting from exposure will be treated as if it were due to injury, provided the loss results directly and independently of all other causes from accidental exposure to the elements.

Disappearance will be considered loss of life when:

(1) The conveyance in which you are riding sinks, wrecks, or disappears as the result of an accident otherwise not excluded from coverage; and
(2) You are not found within one year after the accident.

SEAT BELT RIDER

We will pay an additional benefit of 25% of the amount of the Accidental Death and Dismemberment Death Benefit payable or $25,000, whichever is less if you die as the result of accidental bodily injury.

- As described in WHAT IS ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE; and
- While driving or riding in a private passenger automobile and if your seat belt was properly fastened.

Verification of actual use of the seat belt at the time of the loss must be made part of the official report of the accident, or must be certified in writing by the investigating official(s). However, if such certification is not available, and it is unclear whether the insured was properly wearing a seatbelt, then we will pay a fixed benefit of $1,000.

AIR BAG RIDER

If the Insured team member dies in an automobile, which is equipped with an airbag for the location in the car in which the Insured was seated and the Insured was wearing a properly fastened seatbelt, an additional benefit of 10% of the amount of Accidental Death benefit payable or $5,000, whichever is less may be paid.

COMMON CARRIER DEATH BENEFIT

An additional Common Carrier Benefit will be paid if the Team Member's loss of life occurs while traveling as a fare-paying passenger on a public conveyance operated by a common carrier. The Common Carrier Benefit is 100% of the amount of the Accidental Death Benefit.

REPATRIATION BENEFIT

We will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as a result of a covered accident, you suffer loss of life at least 100 miles away from your principle place of residence.

However, when combined with two or more of Our accidental death and dismemberment insurance plans, the combined overall maximum of these plans together cannot exceed the actual expense for the preparation and transportation of your body to a mortuary.

Maximum Benefit Amount: Up to $2,000

The **Repatriation Benefit** is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

If a Team Members Accidental Death Benefit is payable under this Policy, a Team Member's Dependent Child may be eligible for a Dependent Child Education Benefit.

A Dependent Child is eligible for an Education Benefit if the Dependent Child enrolls as a full-time student at a post-secondary school or college before reaching age 25 and within 1 year after the Team Member's date of death.

The annual Dependent Child's Education Benefit is the lesser of:

a) 5% of the Team Member's Accidental Death Benefit payable; or
b) Incurred Expenses; or
c) $2,500

The annual Dependent Child's Education Benefit is payable at the end of each semester per Dependent Child, for a maximum of four consecutive years per child. Proof of the child's enrollment and Incurred Expenses are required each semester prior to payment of the benefit.

Incurred Expenses include tuition, fees, cost of books, room and board, transportation and any other costs paid directly to the school.

YOUR BENEFICIARY

Your beneficiary is the same as your beneficiary under your Basic Life Insurance Coverage.

ASSIGNMENTS

You may assign your accidental death insurance and benefit under this Coverage. The assignment must be on a form acceptable to the insurance company. See your employer for details.

We are not responsible for the validity of any assignment.

Our acceptance of an assignment does not make Us liable for any action or payment or other settlement We made before that acceptance.

LOSSES WE DO NOT COVER

Your plan does not cover any accidental losses caused by, contributed to or resulting from:

- Suicide while sane or insane.
- Intentionally self-inflicted injury while sane.
- Bodily or mental infirmity or disease of any kind, or infection unless due to an accidental cut or wound.
- Committing or attempting to commit a felony.
- Active participation in a war (declared or undeclared) or active duty in any armed service during a time of war.
- Active participation in a riot, rebellion, or insurrection.
- Injury sustained from any aviation activities, other than riding as a fee-paying passenger.
- The Team Members's being under influence of any narcotic, unless administered or consumed on the advice of a physician.
- The Team Member's operation of any motorized vehicle while intoxicated. Intoxicated means that the minimum blood alcohol level required to be considered operating an automobile under the influence of alcohol in the jurisdiction where the accident occurred. For the purposes of this Exclusion, "motorized Vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

SECTION 8

A LIVING BENEFIT OPTION

(Applies to team member only)

WHAT IS A LIVING BENEFIT?

PROOF

THE BENEFIT

WHEN WE DO NOT PAY

RIGHT TO PAYMENT

EFFECT ON ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS

CANCELLATION

Benefits paid under this section may be taxable. If so, you or your beneficiary may incur a tax obligation. You should consult your personal tax advisor to assess the impact of this benefit.

WHAT IS A LIVING BENEFIT?

You or your legal representative, while you are living and insured under the life insurance coverage, may request that a portion of your amount of life insurance under that coverage be paid to you prior to your death.

To qualify, you must be certified by a doctor as having a sickness or condition that can reasonably be expected to result in death within 24 months of the date of certification

PROOF

Before We will pay under this section, We must receive proof that you meet these conditions, and this proof must be approved by Us. We may also have you examined, at Our expense, by one of Our own doctors.

THE BENEFIT

The amount of your life insurance We will pay as a living benefit is:

- Up to 50% of your life insurance amount shown in Section 1.
- No more than $750,000.

We will pay this amount in one lump sum. If you die after requesting this living benefit but before any payment is made, We will pay your full death benefit to your named beneficiary.

Before We will pay under this section, We may ask your beneficiary, and, in community property states, your spouse, to provide written consent.

The amount of life insurance that We pay at your death will be reduced by any amount we pay as a living benefit. If your life insurance amount reduces when you reach a certain age, and if this occurs after We have made a living benefit payment to you, then your reduced amount of life insurance is figured as follows:

- First We apply the age reduction to your amount of life insurance in effect just prior to Our payment of the living benefit.
- Then We reduce that amount by the amount of the living benefit We paid.

Once We begin payment under this section, your life insurance will be continued without premium charge.

The amount that you may convert under the **How to Convert to Individual Insurance Section** will also be reduced by any amount We pay under this section.

WHEN WE DO NOT PAY

We will not pay under this section if:

- You have assigned your life insurance; or
- All or a portion of your life insurance is to be paid to your former spouse as part of a divorce agreement; or
- You cancel your right to payment under this benefit; or
- You have had the life insurance coverage under this plan for less than 6 months in a row; or
- You have met the conditions for this benefit as a result of attempted suicide or injuring yourself on purpose.

RIGHT TO PAYMENT

Only you have the right to any payment made under this section. No government agency, creditor or any other third party can:

(a) force you to apply for this benefit in order to receive certain third party benefits; or
(b) otherwise make a claim on these proceeds or the benefit available under this section.

For example, no health care facility can require you to apply for this benefit as a condition of admission to the facility or for providing any care in the facility.

EFFECT ON ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS

Receipt of benefits paid under this Section may affect your eligibility for public assistance programs such as Medicaid, Aid to Families with dependent children, and Supplemental Security Income. So, before applying for a living benefit payment, you should consult with the appropriate social services agency. They can advise you on the impact of this benefit on your eligibility under these programs.

CANCELLATION

You have the right to cancel this living benefit at any time upon written request to Us prior to Us releasing the amount requested.

SECTION 9

WHEN INSURANCE ENDS

WHEN YOUR INSURANCE ENDS

WHEN DEPENDENT INSURANCE ENDS

WHEN YOUR INSURANCE ENDS

Your insurance under this coverage will end on the first of these dates:

- The last day of the month which falls on or after the date your employment ends;
- The date the policy (or that coverage under the policy) terminates;
- The date the policy is changed to end coverage for your class;
- The last day of the month which falls on or after the date you are no longer in an eligible class for that coverage;
- The last day of the month that you pay premium for your supplemental life coverage;
- The last day of the period for which a contribution has been made, if you do not make, when due, a required contribution toward the cost of supplemental life insurance. If insurance ends because you do not make that contribution and you apply again, you must give Us proof that you and each dependent that you have is insurable by Our standards. You must provide this proof at your own expense.
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

See the next Section for details on how you may obtain an individual policy when group coverage ends.

WHEN DEPENDENT INSURANCE ENDS

Your dependent's insurance will end on the first of these dates:

- The last day of the month which falls on or after the date your dependent is no longer an eligible dependent;
- The date your insurance ends;
- The date the policy (or that coverage under the policy) terminates;
- The date the policy is changed to end coverage for your dependent's class;
- The last day of the month which falls on or after the date your dependent is no longer in an eligible class for that coverage; the dependent limiting age for coverage is age 19; age 23 for a Full-Time student.
- The last day of the period for which you made any required contributions; or
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness as described in this certificate of coverage.

See the next section for details on how your dependent may obtain an individual policy when group coverage ends.

Whether and to what extent you may continue or change benefits under the plan during an unpaid leave of absence will be determined in accordance with the Employer’s leave of absence policies and procedures. For more information, contact your Human Resources Department.

SECTION 10

HOW TO CONVERT TO INDIVIDUAL INSURANCE

CONVERTING YOUR LIFE INSURANCE

HOW TO APPLY

CONVERTING LIFE INSURANCE FOR YOUR DEPENDENTS

CONVERTING YOUR LIFE INSURANCE

If your life insurance ends under the circumstances described below, you may convert all or part of your Group Term Life Insurance to an individual policy other than term. No proof that you are insurable is needed.

You may convert:

- All or part of your Life Insurance to an individual policy of life insurance, other than term, if your insurance terminated because you cease to be a member of a class eligible for insurance;
- You are at the end of a 12 month extension for a disability that began on or after age 60 but before age 70;
- You are now age 70 and had coverage extended under the waiver of premium benefit for a disability that began before you were 60;
- You are age 70 or older and are no longer able to work due to illness or accident;
- You are age 70 or older and are taking a leave of absence; or
- A limited amount of insurance to an individual policy of life insurance, other than term, if you have been continuously insured under the Policy (or the policy it replaced) for five years and the insurance terminated due to termination or amendment of the policy. The amount you may convert in this case is the smaller of the following:
  a. the amount of Life Insurance which terminates, less the amount you became eligible for under any Policy within 31 days after this insurance terminated; or
  b. $10,000

You may convert to any policy, other than term, We are issuing for the purpose of conversions. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. Written application and the first premium payment for the conversion policy must be received in Our Home Office within 31 days after your insurance terminates. The premium will be based on the amount and the form of the conversion policy, and on your class of risk and age on the date the conversion takes effect. If you die within 31 days after your basic life insurance ends, We will pay your beneficiary the amount We would have allowed you to convert. We will pay this amount under the Group Policy whether or not you applied for that individual policy before your death. If you do apply and name a new beneficiary on the application, We will pay that new beneficiary.

Amounts of insurance that you have ported will not be eligible for the Conversion Privilege unless the Certificate of Portability is returned.

You may convert up to the full amount of your insurance which ends, less any amount We have paid under the **Accelerated Life Insurance Benefit Section**.

The conversion policy will take effect on the later of:

Its date of issue: or
31 days after the date this insurance terminates.

The insurance under the Policy may be reinstated within one year after termination of your employment, if you have converted and:

- Give Us proof that you were totally disabled when your insurance terminated and that your insurance would have continued under the Waiver of Premium-Totally Disabled provision if you had not converted; and
- Surrender the conversion policy to Us without claim in return for premiums paid less any unpaid policy loans.

Team members rehired after converting insurance must either lapse that insurance or provide evidence of insurability to keep that individual policy.

Supplemental Life Limitations: No benefit will be paid for any loss caused directly or indirectly from:

- suicide occurring within 24 months after the Covered Person's initial Effective Date of insurance; or
- suicide occurring within 24 months after the Effective Date of any increase or additional insurance.

HOW TO APPLY

To apply, contact your Human Resources Department.

CONVERTING LIFE INSURANCE FOR YOUR DEPENDENTS

If your dependents life insurance ends under the circumstances described below, he or she may convert to his or her own life insurance policy with Us. No proof that he or she is insurable is needed.

If the dependent's life insurance ends because:

- You died or;
- The policy is terminated; or
- The policy is changed to end life insurance coverage for your dependent's class.

The dependent may convert up to the full amount of his or her insurance if insurance ends for any of the above reasons. If a dependent's insurance ends due to reaching maximum covered age they are not eligible to convert.

The terms of the policy to be issued and the conditions you must meet in order to convert your life insurance also apply to your dependents.

If your dependent dies within 31 days after his or her life insurance ends, We will pay the amount We would have allowed the dependent to convert. We will pay this amount under the Group Policy whether or not the dependent applies for the individual policy before his or her death.

SECTION 11

HOW TO PORTATE YOUR LIFE INSURANCE COVERAGE

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

HOW TO APPLY

WHEN THIS COVERAGE ENDS

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

This provision applies only to the Covered Person's Life Insurance Benefit. It does not apply to Accidental Death and Dismemberment Benefit, as contained in the policy.

You may not elect a portable Certificate of Insurance unless you have been insured by the Policy, or the one it replaced, for at least three consecutive months prior to the date your insurance under the Policy ends.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

You may elect to continue all or part of your Life Insurance Benefit provided *you are under age 70*, by electing a portable Certificate of Insurance, subject to the following terms and conditions. Your life insurance under the Policy ends for any reason *other than*:

- The termination of employment due to Sickness or Injury;
- Failure to pay any required premium; or
- The termination of the Policy.

However, the amount of portable coverage for you will not be more than:

- The full amount of Life Insurance as of the day insurance under the Group Policy terminates.

You can port to a portable Certificate of Insurance. The portable Certificate of Insurance provides term Group Life Insurance. This does not provide Waiver of Premium benefit. The benefits provided by the portable Certificate of Insurance may not be identical to the benefits provided by the Policy.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your employer.

HOW TO APPLY

To get a portable Certificate of Insurance, you must apply to Us in writing for portable coverage and pay the required premium within 31 days from when:

- Your coverage ends, you retire; or
- You begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not allowed to convert your insurance, and elect a portable Certificate of Insurance at the same time. If a situation arises in which you would be eligible to both convert and port, you may only exercise one of these privileges. You may never be insured under both a converted policy and a portable Certificate of Insurance at the same time.

WHEN THIS COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- The date you fail to pay any required premium; or
- The date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Team Members rehired after porting insurance must either lapse that insurance or provide evidence of insurability to keep the porting insurance.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Premium rates may change for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- Changes occur in the coverage levels;
- Changes occur in the overall use of benefits by all insured's;
- Changes occur in other risk factors; or
- A new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis and you will be notified in writing at least 31 days before a premium rate is changed.

If you are not eligible to apply for portable coverage or portable coverage ends, then you may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

SECTION 12

HOW TO FILE A CLAIM

NOTIFY US OF A CLAIM

PROOF OF LOSS

WE CAN REQUIRE EXAMINATIONS AND AUTOPSIES

WHO WE WILL PAY

LEGAL ACTIONS

NOTIFY US OF A CLAIM

To make a claim for benefits, you must notify Us in writing. We must receive your notice within 90 days after a covered loss starts, or as soon after as is reasonably possible.

PROOF OF LOSS

Claim forms are available through your Human Resources Department.

Written proof must be given to Us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. Benefits for loss covered by the policy will be paid immediately upon receipt of proper written proof.

WE CAN REQUIRE EXAMINATIONS AND AUTOPSIES

We have the right to arrange for you to be examined by a Doctor of Our choice at Our expense as often as is reasonably required while a claim is pending. We also have the right to arrange for an autopsy in case of accidental death, if it is not forbidden by law. You must allow Us the opportunity to exercise these rights.

WHO WE WILL PAY

We will pay your death benefit to the beneficiary you named in writing on your application or enrollment form (or on the beneficiary designation form on file with the Group Policyholder). If You did not name a beneficiary, or if your beneficiary dies before you, We will pay your death benefit to your estate. You may change the beneficiary at any time. The change must be in writing on a form approved by Us. The change will not be effective until the date it is recorded. If you are not living on the date the change is recorded, the change will be effective on the date you signed it. However, any benefits paid before the change is recorded will not be subject to it.

Once We make a payment under the terms of the policy, We have no further liability for the amount paid.

LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written proof of loss has been given as required by Us. No such action may be brought after 3 years from the time written proof of loss is required to be given.

We have the right to recover any overpayments due to fraud or any error made in processing a claim.

ERISA INFORMATION

Name of Plan: The New Jersey Hospital Association Insurance Fund.

Name and Address of Plan Sponsor:

The New Jersey Hospital Association Insurance Fund
760 Alexander Road - P.O. Box 1
Princeton, N.J. 08543-0001
(609) 275-4000

Employer Identification Number (EIN) assigned for this Plan by IRS: 22-6136100

Plan number assigned by the Plan Sponsor: 501

Type of Plan: Basic Life Insurance, Accidental Death & Dismemberment Insurance and Supplemental Life Insurance.

Type of Administration: Basic Life, Accidental Death & Dismemberment and Supplemental Life Insurance benefits are provided and administered under an Insurance Contract.

The name, business address and telephone number of the Plan Administrator:

The New Jersey Hospital Association Insurance Fund
760 Alexander Road - P.O. Box 1
Princeton, N.J. 08543-0001
(609) 275-4000

The name and/or title of the person designated as agent for service of legal process and street address at which process may be served on such person:

The New Jersey Hospital Association Insurance Fund
760 Alexander Road - P.O. Box 1
Princeton, N.J. 08543-0001
(609) 275-4000

The Plan is administered by the Plan Administrator which is also the Named Fiduciary for the plan. The Plan Administrator has broad discretionary authority to interpret Plan terms, to determine the status and rights of participants, beneficiaries and other persons, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be sufficient to warrant deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire & Rubber Co. v Bruch.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate fiduciary or other responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Basic Life Insurance, Accidental Death & Dismemberment and Supplemental Life Insurance benefits described in this booklet are provided pursuant to an insurance contract issued to Meridian Health (through the New Jersey Hospital Association) by Metropolitan Life Insurance Co.. Metropolitan Life Insurance Co. is the Claims Administrator for these Plan benefits. The Plan Administrator has delegated to Metropolitan Life Insurance Co. its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract. The Plan Administrator retains all of its other authority.

Waiver:

Failure by the Plan or Plan Administrator to insist upon compliance with any provisions of the plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

Governing Law:

The Plan shall be interpreted under federal law, including ERISA.

Eligibility - Please refer to the section(s) titled "How to Become Insured" and "Dependent Life Insurance" (if applicable) for a description of the eligibility requirements under this plan.

Termination of Coverage - Please refer to the section titled "When Insurance Ends" for a description of when team member and dependent (if applicable) coverage ends under this plan.

Contributions - Please refer to the section titled "Group Coverage at a Glance" - Cost To You for a description of employer/employee contribution requirements.

The Plan year ends on: December 31st of each year

Information Required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA")

The Claims Administrator, Metropolitan Life Insurance Co., is the fiduciary under the plan designated to review any claims and appeals with respect to the policy by a claimant. The Claims Administrator is vested with discretionary authority to determine eligibility for benefits and to construe and interpret the plan/policy terms and provisions. Benefits under the plan will be paid only if the Claims Administrator decides in its sole and complete discretion that the applicant is entitled to them. The Claims Administrator's decision with respect to eligibility and plan/policy terms and provisions is final, conclusive and binding as to all parties.

CLAIMS REVIEW PROCEDURES

Filing Claims

You must file your claim in writing with the Claims Administrator. The Claims Administrator will make its decision regarding your claim and notify you of the determination within 90 days after the claim is filed, unless an extension of up to 90 days is necessary. The Claims Administrator will notify you if an extension is needed within the initial 90-day period. The notice of extension will describe the special circumstances requiring the extension and provide the date the Claims Administrator expects to issue its determination.

If you receive an adverse benefit determination, the Claims Administrator will provide you with a notification, which will include the following: (i) the specific reason(s) for the adverse determination; (ii) reference to the specific plan provisions on which the determination is based; (iii) a description of any additional material or information necessary to process the claim and an explanation of why such material or information is necessary; (iv) a description of the plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following an adverse determination on appeal; and (v) any internal guideline relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

If you do not receive such a notice, you may consider your claim denied.

Claim Appeals

To appeal an adverse benefit determination or deemed denial, you must notify the Claims Administrator within 60 days after you receive notice of the determination. You may submit written comments, documents, records, and other pertinent information and, if requested, you will be given reasonable access to and copies of all documents, records, and other information relevant to the claim upon request and free of charge. The Claims Administrator's review will take into account all comments, documents, records, and other relevant information you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

The Claims Administrator will notify you of the decision on appeal within 60 days after the Claims Administrator's receipt of the appeal, unless special circumstances require an extension of up to 60 days for processing the claim. The notice will explain the special circumstances that require the extension and include the date by which the Claims Administrator expects to issue its determination on review.

If the decision on appeal is an adverse benefit determination, the Claims Administrator will provide you with a notification, which will include the following: (i) the specific reason or reasons for such adverse determination; (ii) reference to the specific plan provisions on which the determination is based; (iii) 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; (iv) a statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA; and (v) 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.

If you do not receive a notice within the stated period of time, you may consider your appeal denied.

DISABILITY CLAIMS REVIEW PROCEDURES

For any claim which requires a determination of disability in connection with the life insurance benefits under the plan, the claimant must complete the appropriate claim form and submit the required proof as described in this summary. Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Claims Decisions

The Claims Administrator will notify you in writing of an adverse benefit determination within 45 days after receipt of your claim. This period may be extended for up to 30 days, if the Claims Administrator determines that an extension is necessary due to matters beyond its control and notifies you, prior to the expiration of the initial 45-day period, of the circumstances that require the extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond its control, it cannot render a decision within that extension period, it may extend the decision period for up to an additional 30 days, if the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances that require the additional extension and the date it expects to render its decision on your claim. In the case of any extension, the notice of extension the Claims Administrator provides you will explain the standards in the plan under which it is reviewing your claim, the unresolved issues that prevent it from rendering a decision on the claim, and the additional information it requires to resolve those issues. You will be afforded at least 45 days within which to provide any additional information the Claims Administrator requires from you.

The Claims Administrator's notification of an adverse determination on your claim will be written or electronic, and will include (i) the specific reason or reasons for the adverse determination, (ii) reference to the specific plan provisions on which it based its determination, (iii) a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary, and (iv) a description of the plan's review procedures, the time limits that apply to the plan's review procedures, and a statement of your right to bring a civil action under ERISA following an adverse benefit determination on the review of your claim.

If you receive an adverse decision on your claim, you will be entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. If the Claims Administrator relies on an internal rule, guideline, protocol, or other similar criterion in making an adverse determination on your claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion, will be provided to you free of charge upon request. In addition, if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims Review Procedures

If the Claims Administrator denies your claim in whole or in part, you may request that the Claims Administrator review its decision (that is, you may "appeal" the denial of your claim). To do so, you must submit a written request for review to the Claims Administrator through the U.S. Postal Service (or other courier service) within 180 days after you receive the adverse determination on your initial claim.

With your written request for review, you may submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. To review your claim, the Claims Administrator will:

- take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether the information was submitted or considered in connection with its initial determination on your claim (if you properly submit the information by the 180-day deadline for requesting review);

- not afford deference to the adverse benefit determination under review;

- conduct your review by an appropriate employee who is neither the individual who made the adverse benefit determination under review, nor the subordinate of such individual;

- consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, if the adverse benefit determination under review is based in whole or in part on a medical judgment, (and will ensure that the health care professional engaged for purposes of this consultation is neither an individual who was consulted in connection with the adverse benefit determination under review, nor the subordinate of any such individual); and

- identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the Claims Administrator relied on the advice in making the benefit determination.

The Claims Administrator will notify you of its determination on review within 45 days after receipt of your request for review, unless it determine that special circumstances (such as, but not limited to, the need to hold a hearing, to submit evidence for review by an independent physician, or to obtain an independent medical exam) require an extension of time for reviewing your claim. If the Claims Administrator determines that it requires an extension of time to review your claim, the Claims Administrator will furnish you with a written notice of the extension prior to the end of the initial 45-day period. The extension will not exceed a period of 45 days from the end of the initial period. The notice will indicate the special circumstances that require an extension and the date by which the Claims Administrator expects to render its determination on review.

The Claims Administrator's notification of an adverse determination upon review of your claim will be written or electronic, and will include (i) the specific reason or reasons for the adverse determination, (ii) reference to the specific plan provisions on which it based its determination, (iii) 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 your claim for benefits, (iv) a statement of your right to bring a civil action under ERISA, and (v) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you receive an adverse decision on your claim, you will be entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. If the Claims Administrator relies on an internal rule, guideline, protocol, or other similar criterion in making an adverse determination on your claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion, will be provided to you free of charge upon request. In addition, if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

CHANGE OR DISCONTINUANCE OF THE PLAN

We reserve the right to modify, amend or terminate, in whole or in part, any or all provisions of the Plan. Amendments may be adopted with retroactive effect to the extent permitted by ERISA and the Code. A Summary of Plan Change describing any material changes or modifications to the Plan will be distributed to all plan participants as required by ERISA.

In addition, the Employer reserves the right to modify, amend or terminate, in whole or in part, at any time the life and AD&D insurance benefits it provides to its employees.

PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Employer and any participant or to be consideration or an inducement for the employment of any participant or Employee. Nothing contained in this Plan shall be deemed to give any participant or Employee the right to be retained in the service of the Employer

or to interfere with the right of the Employer to discharge any participant or Employee at any time regardless of the effect which such discharge shall have upon him as a participant of this Plan.

STATEMENT OF ERISA RIGHTS

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

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

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

3. 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.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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.

N O T I C E

N E W J E R S E Y
L I F E A N D H E A L T H
I N S U R A N C E
G U A R A N T Y
ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to insure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumer's care in selecting companies that are well managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance Companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and
Health Insurance
Guaranty Association
One Gateway Center
7th Floor
Newark, NJ 07102

State of New Jersey
Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverage's, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- o they are eligible for protection under the laws or another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state);
- o the insurer was not authorized to do business in this state;
- o the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption Summary Plan Description was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits or $500,000 in present value of annuities -- again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverage's.

The Association will not pay more than $2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

GROUP INSURANCE SUMMARY PLAN DESCRIPTION

Metropolitan Life Insurance Co. certifies that the person described in Section 2, How To Become Insured, is insured for the insurance under any Coverage elected on his / her enrollment form and described in this booklet, subject to the terms of the Group Policy.

Sections 1 and 3 of this booklet describe who is eligible and when insurance under a Coverage starts.

This booklet is not your Summary Plan Description unless you are an eligible employee and properly enrolled in the Coverage.

This Summary Plan Description is governed by the terms of the Group Policy. It replaces all previous Summary Plan Descriptions issued to you by **Metropolitan Life Insurance Co.** for insurance under any Coverage described in this Summary Plan Description.

Effective Date	January 1, 2016
Group Policy No.	162904
Policyholder is:	THE NEW JERSEY HOSPITAL ASSOCIATION INSURANCE FUND
Participating Employer:	Meridian Health

IMPORTANT NOTICE

You may contact us regarding any type of question you may have by calling (609) 275-4090.

NJHA Insurance Services
P O Box 1
Princeton, NJ 08543-0001